NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected — Rulemaking Action

R9-22-101	Repeal
R9-22-101	New Section
R9-22-103	Repeal
R9-22-114	New Section
R9-22-115	New Section
R9-22-116	New Section
R9-22-117	New Section
Article 3	Repeal
R9-22-301	Repeal
R9-22-302	Repeal
R9-22-303	Repeal
R9-22-304	Repeal
R9-22-305	Repeal
R9-22-306	Repeal
R9-22-307	Repeal
R9-22-308	Repeal
R9-22-309	Repeal
R9-22-310	Repeal
R9-22-311	Repeal
R9-22-312	Repeal
R9-22-313	Repeal
R9-22-314	Repeal
R9-22-315	Repeal
R9-22-316	Repeal
R9-22-317	Repeal
R9-22-318	Repeal
R9-22-319	Repeal
R9-22-320	Repeal
R9-22-321	Repeal
R9-22-322	Repeal
R9-22-323	Repeal
R9-22-324	Repeal
R9-22-325	Repeal
R9-22-326	Repeal
R9-22-327	Repeal
R9-22-328	Repeal
R9-22-329	Repeal
R9-22-330	Repeal
R9-22-331	Repeal
R9-22-332	Repeal
R9-22-333	Repeal
R9-22-334	Repeal
R9-22-335	Repeal
R9-22-336	Repeal
R9-22-337	Repeal

R9-22-338	Repeal
R9-22-339	Repeal
R9-22-340	Repeal
R9-22-341	Repeal
R9-22-342	Repeal
R9-22-343	Repeal
R9-22-344	Repeal
Article 14	New Article
R9-22-1401	New Section
R9-22-1402	New Section
R9-22-1403	New Section
R9-22-1404	New Section
R9-22-1405	New Section
R9-22-1406	New Section
R9-22-1407	New Section
R9-22-1408	New Section
R9-22-1409	New Section
R9-22-1410	New Section
R9-22-1411	New Section
R9-22-1412	New Section
R9-22-1413	New Section
R9-22-1414	New Section
R9-22-1415	New Section
R9-22-1416	New Section
R9-22-1417	New Section
R9-22-1418	New Section
R9-22-1419	New Section
R9-22-1420	New Section
R9-22-1421	New Section
R9-22-1422	New Section
R9-22-1423	New Section
R9-22-1424	New Section
R9-22-1425	New Section
R9-22-1426	New Section
R9-22-1427	New Section
R9-22-1428	New Section
R9-22-1429	New Section
R9-22-1430	New Section
R9-22-1431	New Section
R9-22-1432	New Section
R9-22-1433	New Section
R9-22-1434	New Section
R9-22-1435	New Section
R9-22-1436	New Section
Article 15	New Article
R9-22-1501	New Section
R9-22-1502	New Section
R9-22-1503	New Section
R9-22-1504	New Section
R9-22-1505	New Section
R9-22-1506	New Section
R9-22-1507	New Section
R9-22-1508	New Section
Article 16	New Article
R9-22-1601	New Section
R9-22-1602	New Section
R9-22-1603	New Section
R9-22-1604	New Section
R9-22-1605	New Section
R9-22-1606	New Section
R9-22-1607	New Section
R9-22-1608	New Section
R9-22-1609	New Section
R9-22-1610	New Section
R9-22-1611	New Section

R9-22-1612	New Section
R9-22-1613	New Section
R9-22-1614	Reserved
R9-22-1615	New Section
R9-22-1616	New Section
R9-22-1617	New Section
R9-22-1618	New Section
R9-22-1619	New Section
R9-22-1620	New Section
R9-22-1621	Reserved
R9-22-1622	New Section
R9-22-1623	New Section
R9-22-1624	New Section
R9-22-1625	New Section
R9-22-1626	New Section
R9-22-1627	New Section
R9-22-1628	New Section
R9-22-1629	New Section
R9-22-1630	New Section
R9-22-1631	New Section
R9-22-1632	Reserved
R9-22-1633	New Section
R9-22-1634	New Section
R9-22-1635	Reserved
R9-22-1636	New Section
Article 17	New Article
R9-22-1701	New Section
R9-22-1702	New Section
R9-22-1703	New Section
R9-22-1704	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 2903.01(H)

   Implementing statute: A.R.S. §§ 2901(4), 36-2903.01(D), (H), and (K), 36-2903.03, 36-2904(G), 36-2905, 36-2905.03, 36-2908, 36-2909 and 11-297

3. **The effective date of the rules:**

   January 8, 1999

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   Notice of Rulemaking Docket Opening: 3 A.A.R. 868, March 28, 1997.
   Notice of Rulemaking Docket Opening: 4 A.A.R. 255, January 16, 1998.
   Notice of Rulemaking Docket Opening: 4 A.A.R. 2844-2845, October 2, 1998.
   Notice of Proposed Rulemaking: 4 A.A.R. 2752-2825, October 2, 1998.

5. **The name and address of agency personnel with whom applicants may communicate regarding the rulemaking:**

   Name: Cheri Tomlinson, Federal and State Policy Administrator

   Address: AHCCCSA, Office of Policy Analysis and Coordination
   801 East Jefferson, Mail Drop 4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4198

   Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   The 44 Sections (R9-22-301 through R9-22-344) in 9 A.A.C. 22, Article 3 that define the eligibility and enrollment requirements for the Title XIX and nonTitle XIX process have been replaced by 4 Articles (9 A.A.C. 22, Article 14 through 9 A.A.C. 22, Article 17) to clarify and simplify the rule language by organizing the information into more logical components by specific eligibility programs. This ensures that users can quickly locate and understand the differing requirements of Title XIX and non-Title XIX related programs.

   Changes were also made to the rule language to:

   - Comply with recommendations made in the January 7, 1997, 5-Year-Review;
   - Update or revise references to statute, the United State Code, and Code of Federal Regulation; and

- Cross-reference requirements to other rules, whenever possible.

Much of the language in 9 A.A.C. 22, Article 14 and 9 A.A.C. 22, Article 15 is new rule language based on federal and state requirements. The language in 9 A.A.C. 22, Article 16 and 9 A.A.C. 22, Article 17 is primarily derived from existing language in 9 A.A.C. 22, Article 3.

As a result of the changes to 9 A.A.C. 22, Article 3, the definitions in 9 A.A.C. 22, Article 1, Definitions, have been deleted or moved to 1 of 4 new Sections (R9-22-114 through R9-22-117). In addition, several new definitions have been added.

7. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study, and other supporting material:**
   Not applicable.

8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

9. **The summary of the economic, small business, and consumer impact:**
   County eligibility offices will be nominally impacted for:

   - The cost of telephonic interviews for a limited number of state-only program applicants residing in geographically isolated areas. Current rule does not make provision for this.
   - The cost of conducting a limited number of early redeterminations for state-only program households when an adult household member leaves the household. Current policy requires a redetermination only when the head-of-household leaves.

   However, the county eligibility offices may also benefit from administrative savings resulting from 2 other changes for the State-only program because:

   - A 2nd interviewer will no longer need to be present for a telephonic interview.
   - It will no longer be necessary for counties to send a 2nd notice of confirmation of appointment to applicants.

   AHCCCS applicants and members will be nominally impacted and will benefit from the changes in state-only program because:

   - ADA persons and applicants without transportation who live in a geographically isolated area will not need to arrange transportation to an eligibility interview.
   - Persons will have the option of requesting a different interview appointment time. Current rule does not specifically provide for this option.
   - Newly approved members will no longer be required to repeat an interview face-to-face when a telephonic interview has been successfully completed and all documentation provided to the county.

   The following entities will not be directly impacted by the changes but will benefit because the rule language is clearer and more detailed:

   - The Administration, and
   - AHCCCS contractors.

10. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

	Rule Citation	Change
1.	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, and punctuation changes throughout the proposed rule.
2.	General	The Administration changed passive to active voice throughout the proposed rule.
3.	General	The Administration made the rules more clear, concise, and understandable by reorganizing the following sections: R9-22-1406, R9-22-1408, R9-22-1411, R9-22-1414 through R9-22-1416, R922-1419 through R9-22-1422, R9-22-1426 through R9-22-1431, R9-22-1433, and R9-22-1436.
4.	R9-22-114(18)	The Administration added language to clarify that a subcontractor or contract agent of the Division of Child Support Enforcement is included in the definition of DCSE.

5.	R9-22-114(25)	The Administration amended the proposed language to make the definition of a foster child less restrictive.
6.	R9-22-114(43)	The Administration added language to clarify that Title IV-D refers to the establishment of a child support enforcement program.
7.	R9-22-116(1)	The Administration amended the definition of "1-time income" to clarify that only cash contributions received in the 3-month income period are considered in determining income.
8.	R9-22-1411(F)	The Administration deleted the situations identified as "good cause" because it is impossible to identify all of the situations which may be considered good cause and to increase the Department's flexibility to determine circumstances which are beyond a person's control.
9.	R9-22-1434(A)	The Administration amended the proposed language to clarify that the applicant is determined eligible following the application process.
10.	R9-22-1434(B)	The Administration amended the proposed language to clarify that the postpartum period begins on the day the pregnancy terminates.
11.	R9-22-1603(C)	The Administration added language to clarify that providers shall provide the county with the following, if known: Patient's physical and mailing address; For a patient who is a dependent child, the parent or responsible relative's social security number;, and The patient's discharge date and time.
12.	R9-22-1603(D)(2)(a)	The Administration amended the proposed language to clarify that the county eligibility staff will either conduct an interview or provide a written notification of a scheduled appointment.
13.	R9-22-1604(A)	The Administration moved the language from R9-22-1604(A)(5) and deleted R9-22-1604(A)(5) to clarify that the application date is the date of the postmark or, if there is no postmark, the date of receipt by the county eligibility staff. The Administration also amended subsections(A)(1) through(A)(3) to clarify that the time-frame begins with the application date. The Administration deleted subsection(A)(4) because it was unnecessary.
14.	R9-22-1605(A)(2) R9-22-1608(D) R9-22-1608(E)(7) R9-22-1608(G) R9-22-1608(G)(6)(a)	The Administration amended the proposed language to eliminate the requirement to conduct a face-to-face interview following a telephonic interview.
15.	R9-22-1608(D)	The Administration amended R9-22-1608(D) to: Remove the requirement that a patient shall have been previously eligible for AHCCCS; and Provide flexibility to allow telephonic interviews for geographically isolated persons who can not get out due to reasons other than lack of transportation, such as inclement weather;
16.	R9-22-1608(D)(3)	The Administration added language to clarify the meaning of reasonable accommodation.
17.	R9-22-1626(C)(1)	The Administration amended the proposed language to clarify that this rule refers to payments that are received cyclically, but less often than quarterly, for example, semi-annual or annual payments.
18.	R9-22-1626(D)(11)	The Administration added language to allow benefits received for educational purposes from the Bureau of Indian Affairs student assistance program to be disregarded in considering income.
19.	R9-22-1626(G)(3)	The Administration added language to clarify the meaning of sponsor.

11. A summary of the principal comments and the agency response to them:

The Administration received comments from several Arizona counties regarding the MI/MN program. The Administration clarified rules regarding the application date for person facing the loss of categorically eligible status, resource determination, income determination, and enrollment through discussions with the counties or minor changes in the proposed rules. The Administration amended the proposed rules to expedite the priority application process and the eligibility determination process.

Larry J. Richmond, P.C., who represents several Arizona counties, asked whether the Statement of Completion identified in R9-22-1608(H) will require the counties to complete new or additional forms. The Administration does not anticipate creating a new form for the Statement of Completion. However, the Administration amended the language in the current rule which requires the Statement of Completion to appear on the Part II, to allow flexibility in the event that changes to the Part II become necessary.

The Administration received comments from the Department of Economic Security regarding 9 A.A.C. 22, Article 14, Title IV-A Related Eligibility, including foster care and medical support enforcement activities, and the corresponding definitions in 9 A.A.C. 22, Article 1. The Administration provided clarification to the Department through discussions with the Department or through minor changes in the proposed rules. The Administration eliminated the restrictive definition of good cause in R9-22-1411(G) to enhance the Department's flexibility in determining good cause reasons outside of those identified.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable.

13. Incorporations by reference and their location in the rules:

Description	Date	Location
Section 1931 of the Social Security Act (42 U.S.C. 1396u-1)	July 1, 1997	R9-22-1406(B)(1) and R9-22-1406(C)
42 CFR 435.115(f) and (g)	December 21, 1990	R9-22-1406(C)
42 CFR 435.227	December 21, 1990	R9-22-1406(E)
42 U.S.C. 1396a(e)(1)	July 1, 1997	R9-22-1406(F)(1)
42 U.S.C. 1396r-6	August 5, 1997	R9-22-1406(F)(1)
42 CFR 435.904	October 24, 1994	R9-22-1407(C)(5)
42 CFR 435.1009	July 1, 1995	R9-22-1416(C)(2)(b)
42 CFR 435.608	August 18, 1993	R9-22-1421
42 CFR 435.910 and 42 CFR 435.920	May 29, 1986	R9-22-1423(A)
42 CFR 435.403	December 21, 1990	R9-22-1424
42 CFR 435.210	August 18, 1994	R9-22-1501(A)(1)
42 U.S.C. 1396a(a)(10)(A)(i)(II)	July 1, 1997	R9-22-1501(A)(2)
Section 211(d)(2)(B) of Subtitle B of P.L. 104-193	July 1, 1997	R9-22-1501(A)(2)(b)
42 CFR 435.403	December 21, 1990	R9-22-1503
42 U.S.C. 1382(a)(2)(B)	August 5, 1997	R9-22-1506(A)
42 U.S.C. 1382(a)	August 5, 1997	R9-22-1507(A)(1)
42 U.S.C. 1382a	August 22, 1996	R9-22-1507(A)(1)
42 U.S.C. 1382a(a)(2)(A)	August 22, 1996	R9-22-1507(A)(2)(a)
20 CFR 416.1163(b)(1) and (2)	May 4, 1989	R9-22-1507(A)(2)(c)
20 CFR 416.1165(b)	January 8, 1997	R9-22-1507(A)(2)(e)
42 U.S.C. 1383c(c)	March 29, 1996	R9-22-1507(A)(3)(a)
42 U.S.C. 1383c(b) and (d),	March 29, 1996	R9-22-1507(A)(3)(b)
42 CFR 435.135	May 12, 1986	R9-22-1507(A)(3)(c)

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:

No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 1.DEFINITIONS

Section

~~R9-22-101.~~ ~~Location of Definitions~~
R9-22-101. Location of Definitions
~~R9-22-103.~~ ~~Eligibility and Enrollment Related Definitions~~
R9-22-114. Title IV-A Related Definitions
R9-22-115. SSI MAO Related Definitions
R9-22-116. State-Only Eligibility Related Definitions
R9-22-117. Enrollment Related Definitions

~~ARTICLE 3. ELIGIBILITY AND ENROLLMENT~~

~~R9-22-301. Residency Requirements for Indigent and Medically Needy Applicants and Eligible Low-income Children~~
~~R9-22-302. Citizens and Aliens~~
~~R9-22-303. Application and eligibility determination process for the categorically eligible and eligible assistance children~~
~~R9-22-304. Retroactive coverage for the categorically eligible~~
~~R9-22-305. Redeterminations for the categorically eligible and eligible assistance children~~
~~R9-22-306. Initiating the Routine and Priority Application for Indigent and Medically Needy Applicants and Eligible Low-income Children~~
~~R9-22-307. AHCCCS Family Household and Relationship for Indigent and Medically Needy Applicants and Eligible Low-income Children~~
~~R9-22-308. Notification Requirements in Cases of Applicants Receiving Medical Care~~
~~R9-22-309. Completing the Application for Indigent and Medically Needy Applicants, Eligible Low-income Children, and State Emergency Services Applicants~~
~~R9-22-310. Face-to-face Interview for Indigent and Medically Needy Applicants and Eligible Low-income Children~~
~~R9-22-311. Head of household's Responsibility for Indigent and Medically Needy Applicants, Eligible Low-income Children, and State Emergency Services Applicants~~
~~R9-22-312. Statement of Truth for Indigent and Medically Needy Applicants, Eligible Low-income Children, State Emergency Services Applicants, and Title XIX Applicants~~
~~R9-22-313. Determination of Eligibility for Indigent and Medically Needy Applicants, Eligible Low-income Children, and State Emergency Services Applicants~~
~~R9-22-314. Effective Date of AHCCCS Eligibility for Indigent and Medically Needy Individuals and Eligible Low-Income Children~~
~~R9-22-315. County Referrals for Applicants Potentially Eligible under Title XIX Eligibility Categories~~
~~R9-22-316. Notice to indigent and medically needy applicants and applicants for low-income children eligibility~~
~~R9-22-317. Notice to contractors and nonproviders~~
~~R9-22-318. Reasons for Denial or Discontinuance of Eligibility for the Indigent and Medically Needy and Eligible Low-income Children~~
~~R9-22-319. Action After Eligibility Denial or Discontinuance~~
~~R9-22-320. Repealed~~
~~R9-22-321. Income for the Indigent and Medically Needy and Eligible Low-income Children~~
~~R9-22-322. Determining Annual Income for the Indigent, the Medically Needy and Eligible Low-income Children~~
~~R9-22-323. Resources for the Indigent, the Medically Needy and Eligible Low-income Children~~
~~R9-22-324. Evaluating Resources~~
~~R9-22-325. Ownership of Resources~~
~~R9-22-326. Transfer of resources for the indigent, the medically needy, and eligible low-income children~~
~~R9-22-327. Verification of Information for the Indigent, the Medically Needy, and Eligible Low-income Children~~
~~R9-22-328. Redeterminations for the indigent, the medically needy, and eligible low-income children~~
~~R9-22-329. Date of AHCCCS coverage for categorically eligible applicants and eligible assistance children~~
~~R9-22-330. Reporting interim changes for the indigent, the medically needy and eligible low-income children~~
~~R9-22-331. Re-evaluation of the Indigent, the Medically Needy, and Eligible Low-income Children~~
~~R9-22-332. Eligibility Offices; Hours and Location~~
~~R9-22-333. Enrollment of Eligible Applicants with AHCCCS Contractors~~
~~R9-22-334. Communication of Eligibility for the Indigent, the Medically Needy, and Eligible Low-Income Children~~
~~R9-22-335. Notice to contractors and effective date of enrollment for individuals eligible for AHCCCS~~
~~R9-22-336. Deferred liability~~
~~R9-22-337. Guaranteed enrollment for categorically eligible applicants and eligible assistance children~~
~~R9-22-338. Verification review by the Director for the indigent, the medically needy, and low-income children~~
~~R9-22-339. Newborn Eligibility~~
~~R9-22-340. Eligibility and enrollment for pregnant women~~
~~R9-22-341. Priority processing of medically needy and indigent applications of applicants facing a loss of categorically eligible status as a result of the termination of SSI benefits~~
~~R9-22-342. Newborn Enrollment~~
~~R9-22-343. Eligibility for State Emergency Services~~
~~R9-22-344. Eligibility for Medicare Beneficiaries~~

ARTICLE 14. TITLE IV-A RELATED ELIGIBILITY

R9-22-1401. Scope and Applicability
R9-22-1402. Agency Responsible for Determining Eligibility
R9-22-1403. Confidentiality
R9-22-1404. Case Record
R9-22-1405. Manuals
R9-22-1406. Eligibility Coverage Groups and an Eligible Applicant
R9-22-1407. Application
R9-22-1408. Applicant and Recipient Responsibility
R9-22-1409. Death of an Applicant
R9-22-1410. Withdrawal of Application
R9-22-1411. Initial Eligibility Interview

R9-22-1412. Withdrawal from the Medical Assistance Program
R9-22-1413. Verification of Eligibility Information
R9-22-1414. Processing the Application - Approvals and Denials
R9-22-1415. Review
R9-22-1416. Notice of Termination Action
R9-22-1417. Reinstatement of Medical Assistance
R9-22-1418. Dependent Child Living with Specified Relative
R9-22-1419. Assistance Unit
R9-22-1420. Deprivation
R9-22-1421. Application for Other Benefits
R9-22-1422. Assignment of Rights; Cooperation
R9-22-1423. Social Security Number
R9-22-1424. State Residency
R9-22-1425. Citizenship and Alien Status
R9-22-1426. Resources
R9-22-1427. Determining Resource Eligibility
R9-22-1428. Income
R9-22-1429. Earned Income Disregards
R9-22-1430. Determining Income Eligibility
R9-22-1431. Effective Date of Eligibility
R9-22-1432. Prior Quarter Eligibility
R9-22-1433. Deemed Newborn Eligibility
R9-22-1434. Extended Medical Assistance Coverage for a Pregnant Woman
R9-22-1435. Family Planning Services Extension Program
R9-22-1436. Eligibility Appeals

ARTICLE 15. SSI MAO ELIGIBILITY

R9-22-1501. SSI Medical Assistance Only (MAO) Coverage Groups
R9-22-1502. Eligibility Determination Process
R9-22-1503. State Residency
R9-22-1504. Citizenship and Qualified Alien Status
R9-22-1505. Social Security Enumeration
R9-22-1506. Resource Criteria for SSI MAO Eligibility
R9-22-1507. Income Criteria for Eligibility
R9-22-1508. Changes and Redeterminations

ARTICLE 16. STATE-ONLY ELIGIBILITY

R9-22-1601. Who May Apply for MI/MN Benefits
R9-22-1602. Application for MI/MN Benefits
R9-22-1603. Priority Applications for MI/MN Eligibility
R9-22-1604. MI/MN Applications for Applicants Facing a Loss of Categorically Eligible Status Due to Termination of SSI Benefits
R9-22-1605. Responsibilities of the Head-of-Household for MI/MN Eligibility
R9-22-1606. MI/MN Statement of Truth by the Head-of-Household
R9-22-1607. Notice of Reapplication
R9-22-1608. County Responsibility for Completion of MI/MN Eligibility Determination
R9-22-1609. MI/MN Timeliness Requirements
R9-22-1610. Forwarding Applications to Obtain Categorical Eligibility
R9-22-1611. Eligibility for Medicare Beneficiaries
R9-22-1612. State-Funded Coverage for Children
R9-22-1613. State Emergency Service Program (SESP)
R9-22-1614. Reserved
R9-22-1615. Certification Periods
R9-22-1616. Denial or Discontinuance of MI/MN Eligibility
R9-22-1617. Notice of Action for Eligibility
R9-22-1618. Communication of Eligibility Determinations to the Administration
R9-22-1619. Rights Following Receipt of a Notice of Denial or Discontinuance of Coverage
R9-22-1620. Retroactive Coverage for MI/MN, ELIC, and SESP
R9-22-1621. Reserved
R9-22-1622. Verification of Information for MI/MN Eligibility
R9-22-1623. Residence Requirements for MI/MN Eligibility
R9-22-1624. Citizenship and Alien Status Requirements for MI/MN Eligibility
R9-22-1625. Household Composition for MI/MN Eligibility
R9-22-1626. Annual Income for MI/MN Eligibility
R9-22-1627. Resources for MI/MN Eligibility
R9-22-1628. Transfer of Resources for MI/MN Eligibility
R9-22-1629. Assignment of Rights
R9-22-1630. MI/MN Interim Changes
R9-22-1631. MI/MN Redeterminations
R9-22-1632. Reserved
R9-22-1633. Case Record for MI/MN Applications
R9-22-1634. Eligibility Office Locations and Hours of Operation
R9-22-1635. Reserved
R9-22-1636. Verification Review by the Director

ARTICLE 17. ENROLLMENT

R9-22-1701. Enrollment of a Member with an AHCCCS Contractor
R9-22-1702. Effective Date of Enrollment with a Contractor and Notification to the Contractor
R9-22-1703. Newborn Enrollment
R9-22-1704. Categorical and EAC Guaranteed Enrollment Period

ARTICLE 1. DEFINITIONS

~~**R9-22-101. Location of Definitions**~~

~~A. Location of definitions. Definitions applicable to Chapter 22 are found in the following:~~

~~Definition~~	~~Section or Citation~~
~~1. "1st party liability"~~	~~R9-22-110~~
~~2. "3rd party"~~	~~R9-22-110~~
~~3. "3rd party liability"~~	~~R9-22-110~~
~~4. "Accommodation"~~	~~R9-22-107~~
~~5. "Acute mental health services"~~	~~R9-22-112~~
~~6. "AFDC"~~	~~R9-22-101~~
~~7. "Aggregate"~~	~~R9-22-107~~
~~8. "AHCCCS"~~	~~R9-22-101~~
~~9. "AHCCCS disqualified dependent"~~	~~R9-22-103~~
~~10. "AHCCCS disqualified spouse"~~	~~R9-22-103~~
~~11. "AHCCCS hearing officer"~~	~~R9-22-108~~
~~12. "AHCCCS inpatient hospital day or days of care"~~	~~R9-22-107~~
~~13. "Ambulance"~~	~~R9-22-102~~
~~14. "Ancillary department"~~	~~R9-22-107~~
~~15. "Appeal"~~	~~R9-22-108~~
~~16. "Applicant"~~	~~R9-22-101~~
~~17. "Application"~~	~~R9-22-101~~
~~18. "Assignment"~~	~~R9-22-101~~
~~19. "Billed charges"~~	~~R9-22-107~~
~~20. "Capital costs"~~	~~R9-22-107~~
~~21. "Capped fee-for-service"~~	~~R9-22-101~~
~~22. "Case record"~~	~~R9-22-103~~
~~23. "Categorically eligible"~~	~~A.R.S. § 36-2901(4)(b)~~
~~24. "Certification error"~~	~~A.R.S. § 36-2905.01~~
~~25. "Certification period"~~	~~R9-22-103~~
~~26. "Clean claim"~~	~~A.R.S. § 36-2904~~
~~27. "Contract"~~	~~R9-22-101~~
~~28. "Contractor"~~	~~R9-22-101~~

29. "Contractor of record" R9-22-101
30. "Copayment" R9-22-107
31. "Cost-to-charge ratio" R9-22-107
32. "County eligibility worker" R9-22-103
33. "Covered charges" R9-22-107
34. "Covered services" R9-22-102
35. "CPT" R9-22-107
36. "Date of application" R9-22-103
37. "Date of determination" R9-22-103
38. "Day" R9-22-101
39. "Deemed date of application" R9-22-103
40. "Dentures" R9-22-102
41. "Dependent child" R9-22-103
42. "DES" R9-22-103
43. "Determination" R9-22-103
44. "Diagnostic services" R9-22-102
45. "Disenrollment" R9-22-103
46. "Disqualified household member" R9-22-103
47. "DME" R9-22-102
48. "DRI inflation factor" R9-22-107
49. "Eligible assistance children" A.R.S. § 36-2905.03(B)
50. "Eligible low-income children" A.R.S. § 36-2905.03(C) and (D)
51. "Eligible applicant" A.R.S. § 36-2901(4)
52. "Emancipated minor" R9-22-103
53. "Emergency medical condition" 42 U.S.C. 1396b(v)
54. "Emergency medical services" R9-22-102
55. "Encounter" R9-22-107
56. "Enrollment" R9-22-103
57. "E.P.S.D.T. services" R9-22-102
58. "Equity" R9-22-103
59. "Expressed emancipated minor" R9-22-103
60. "Facility" R9-22-101
61. "Factor" R9-22-101
62. "Fair consideration" R9-22-103
63. "Federal emergency services program" R9-22-101
64. "Full cash value" R9-22-103
65. "Grievance" R9-22-108
66. "Gross earnings from employment" R9-22-103
67. "GSA" R9-22-101
68. "Guardian" R9-22-103
69. "Head-of-household" R9-22-103
70. "Hearing aid" R9-22-102
71. "Home health services" R9-22-102
72. "Hospital" R9-22-101
73. "ICU" R9-22-107
74. "Incapacitated applicant" R9-22-103
75. "Income in kind" R9-22-103
76. "Indigent" A.R.S. § 11-297
77. "Inmate of a public institution" 42 CFR 435.1009
78. "Interim change" R9-22-103
79. "License or licensure" R9-22-101
80. "Liquid assets" R9-22-103
81. "Medical education costs" R9-22-107
82. "Medical record" R9-22-101
83. "Medical review" R9-22-107
84. "Medical services" R9-22-101
85. "Medical supplies" R9-22-102
86. "Medically necessary" R9-22-101
87. "Medicare claim" R9-22-107
88. "Medicare HMO" R9-22-101
89. "MI/MN" A.R.S. § 36-2901(4)(a) and (c)
90. "Minor" R9-22-103
91. "New hospital" R9-22-107
92. "NF" 42 U.S.C. 1396r(a)
93. "NICU" R9-22-107
94. "Noncontracting provider" A.R.S. § 36-2931
95. "Occupational therapy" R9-22-102
96. "Open enrollment" R9-22-103
97. "Operating costs" R9-22-107
98. "Outlier" R9-22-107
99. "Outpatient hospital service" R9-22-107
100. "Ownership change" R9-22-107
101. "Peer group" R9-22-107
102. "Pharmaceutical service" R9-22-102
103. "Physical therapy" R9-22-102
104. "Physician" R9-22-102
105. "Practitioner" R9-22-102
106. "Prescription" R9-22-102
107. "Primary care provider" R9-22-102
108. "Primary care provider services" R9-22-102
109. "Prior authorization" R9-22-102
110. "Private duty nursing services" R9-22-102
111. "Prospective rates" R9-22-107
112. "Prospective rate year" R9-22-107
113. "Public assistance" R9-22-103
114. "Quality management" R9-22-105
115. "Radiology services" R9-22-102
116. "Rebasing" R9-22-107
117. "Redetermination" R9-22-103
118. "Referral" R9-22-101
119. "Refusal to cooperate" R9-22-103
120. "Rehabilitation services" R9-22-102
121. "Reinsurance" R9-22-107
122. "RFP" R9-22-105
123. "Respiratory therapy" R9-22-102
124. "Scope of services" R9-22-102
125. "SDAD" R9-22-107
126. "Separate property" R9-22-103
127. "Service location" R9-22-101
128. "Service site" R9-22-101
129. "S.O.B.R.A." R9-22-103
130. "Specialist" R9-22-102
131. "Specified relative" R9-22-103
132. "Speech therapy" R9-22-102
133. "Spend-down" R9-22-103
134. "Spouse" R9-22-103
135. "SSA" P.L. 103-296, Title I
136. "SSI" R9-22-103
137. "State emergency services program" R9-22-101
138. "Sterilization" R9-22-102
139. "Subcontract" R9-22-101
140. "Tier" R9-22-107
141. "Tiered per diem" R9-22-107
142. "Total inpatient hospital days" R9-22-107
143. "Untimely application" R9-22-103
144. "Utilization management" R9-22-105
145. "Work-related expenses" R9-22-103

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "AFDC" means Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended.
2. "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which

health care services are provided to an eligible applicant or member.

3. "Applicant" means a applicant who submits, or on whose behalf is submitted, a written, signed, and dated application for AHCCCS benefits which has been either completed or denied.
4. "Application" means an official request for AHCCCS benefits made in accordance with Article 3.
5. "Assignment" means enrollment of an eligible applicant with a contractor by the AHCCCS Administration.
6. "Capped fee-for-service" means the payment mechanism by which providers of care are reimbursed upon submission of valid claims for specific AHCCCS covered services and equipment provided to eligible applicants. Payments are made in accordance with an upper, or capped, limit as established by the Director.
7. "Continuous stay" means the period of time during which an eligible applicant or member receives inpatient hospital services without interruption beginning with the day of admission, and ending with the day of discharge or date of death.
8. "Contract" means a written agreement entered into between a applicant, organization, or other entity and the Administration to provide health care services to members under the provisions of A.R.S. Title 36, Chapter 29, and these rules.
9. "Contractor" means a applicant, organization, or entity that agrees through a direct contracting relationship with the Administration to provide goods and services specified by the contract in conformance with the requirements of the contract and these rules.
10. "Contractor of record" means the organization or entity in which a member is enrolled for the provision of AHCCCS services.
11. "Day" means a calendar day unless otherwise specified in the text.
12. "Eligible applicant" has the meaning in A.R.S. § 36-2901(4).
13. "Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, according to A.R.S. Title 36, Chapter 4, to provide medical services, nursing services, or other health care or health related services.
14. "Factor" means an organization, collection agency, service bureau, or individual who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, collection agency, service bureau, or individual which receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor" does not include business representatives, such as billing agents or accounting firms as described within these rules, or health care institutions.
15. "Federal emergency services program" means a program designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically eligible applicant who is determined eligible according to A.R.S. § 36-2903.03.
16. "GSA" means a geographical service area designated by the Administration within which a contractor of record provides, directly or through subcontract, covered health care services to members enrolled with that contractor of record.
17. "Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of certification.
18. "Indigent" means meeting income and resource criteria according to A.R.S. § 11-297.
19. "Inmate of a public institution" means a applicant defined by 42 CFR 435.1009.
20. "License" or "licensure" means a nontransferable authorization that is based on established standards in law, is issued by a state or county regulatory agency or board, and allows a health care provider to render a health care service lawfully.
21. "Medical record" means all documents that relate to medical and behavioral health services provided to an eligible applicant or member and that are kept at the site of the provider.
22. "Medical services" means health care services provided to an eligible applicant or member by a physician, practitioner, dentist, or by health professionals and technical personnel under the direction of a physician, practitioner, or dentist.
23. "Medically necessary" means covered services provided by and within the scope of practice under state law of a physician or other licensed practitioner of the healing arts to:
    a. Prevent disease, disability, and other adverse health conditions or their progression, or
    b. Prolong life.
24. "Medicare HMO" means a health maintenance organization that has a current contract with the Health Care Financing Administration (HCFA) for participation in the Medicare program according to 42 CFR 417(L).
25. "MI/MN" means medically indigent and medically needy as defined A.R.S § 36-2901(4)(a) and (c).
26. "Noncontracting provider" has the meaning in A.R.S. § 36-2931.
27. "NF" means nursing facility as is defined in 42 U.S.C. 1396r(a).
28. "Referral" means the process by which an eligible applicant or member is directed by a primary care provider or attending physician to another appropriate provider or resource for diagnosis or treatment.
29. "Service location" means any location at which a member obtains any health care service provided by the contractor of record under the terms of a contract.
30. "Service site" means a location designated by the contractor of record as the location at which a member is to receive health care services.
31. "State emergency services program" means a program designed to provide emergency medical services identified as covered under A.A.C. R9-22-217 to treat an emergency medical condition for a applicant who is determined eligible according to A.R.S. § 36-2905.05.
32. "Subcontract" means an agreement entered into by a contractor with any of the following:
    a. A provider of health care services who agrees to furnish covered services to members;
    b. A marketing organization; and
    c. Any other organization or applicant who agrees to perform any administrative function or service for

~~the contractor specifically related to securing or fulfilling the contractor's obligations to the Administration under the terms of a contract.~~

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 22 are found in the following:

Definition	Section or Citation
1. "210"	R9-22-114
2. "1931"	R9-22-114
3. "1-time income"	R9-22-116
4. "1st-party liability"	R9-22-110
5. "3-month income period"	R9-22-116
6. "3rd-party"	R9-22-110
7. "3rd-party liability"	R9-22-110
8. "Accommodation"	R9-22-107
9. "Act"	R9-22-114
10. "Acute mental health services"	R9-22-112
11. "Adequate notice"	R9-22-114
12. "Administration"	R9-22-114
13. "Adverse action"	R9-22-114
14. "AEC"	R9-22-117
15. "Aged"	R9-22-115
16. "Aggregate"	R9-22-107
17. "AHCCCS"	R9-22-101
18. "AHCCCS hearing officer"	R9-22-108
19. "AHCCCS inpatient hospital day or days of care"	R9-22-107
20. "Ambulance"	R9-22-102
21. "Ancillary department"	R9-22-107
22. "Annual enrollment choice"	R9-22-117
23. "Appeal"	R9-22-108
24. "Appellant"	R9-22-114
25. "Applicant"	R9-22-101
26. "Application"	R9-22-101
27. "Assignment"	R9-22-101
28. "Assistance unit"	R9-22-114
29. "Authorized representative"	R9-22-114
30. "Auto-assignment algorithm"	R9-22-117
31. "Baby Arizona"	R9-22-114
32. "BHS"	R9-22-114
33. "Billed charges"	R9-22-107
34. "Blind"	R9-22-115
35. "Bona fide funeral agreement"	R9-22-114
36. "Burial plot"	R9-22-114
37. "Capital costs"	R9-22-107
38. "Capped fee-for-service"	R9-22-101
39. "Caretaker relative"	R9-22-114
40. "Case record"	R9-22-101
41. "Cash assistance"	R9-22-114
42. "Categorically eligible"	A.R.S. § 36-2901(4)(b) and 36-2934
43. "Certification error"	A.R.S. § 36-2905.01
44. "Certification period"	R9-22-115 and R9-22-116
45. "Child welfare agency"	R9-22-114
46. "Clean claim"	A.R.S. § 36-2904
47. "CMDP"	R9-22-117
48. "Continuous stay"	R9-22-101
49. "Contract"	R9-22-101
50. "Contractor"	R9-22-101
51. "Contractor of record"	R9-22-101
52. "Copayment"	R9-22-107
53. "Cost-to-charge ratio"	R9-22-107
54. "Countable income"	R9-22-116
55. "County eligibility staff"	R9-22-116
56. "Covered charges"	R9-22-107
57. "Covered services"	R9-22-102
58. "CPT"	R9-22-107
59. "CRS"	R9-22-114
60. "Date of determination"	R9-22-116
61. "Date of discontinuance"	R9-22-116
62. "Date of enrollment action"	R9-22-117
63. "Day"	R9-22-101
64. "DCSE"	R9-22-114
65. "Deductible medical expense"	R9-22-116
66. "Deemed application date"	R9-22-116
67. "Dentures"	R9-22-102
68. "Department"	R9-22-114
69. "Dependent child"	R9-22-114 and R9-22-116
70. "DES"	R9-22-101
71. "Determination"	R9-22-116
72. "Diagnostic services"	R9-22-102
73. "Disabled"	R9-22-115
74. "Discontinuance"	R9-22-116
75. "Disenrollment"	R9-22-117
76. "District Medical Consultant"	R9-22-114
77. "DME"	R9-22-102
78. "DRI inflation factor"	R9-22-107
79. "E.P.S.D.T. services"	R9-22-102
80. "EAC"	R9-22-101
81. "Earned income"	R9-22-116
82. "Educational income"	R9-22-116
83. "ELIC"	R9-22-101
84. "Eligibility determination date"	R9-22-114
85. "Eligible assistance children"	A.R.S. § 36-2905.03(B)
86. "Eligible applicant"	A.R.S. § 36-2901(4)
87. "Eligible low income children"	A.R.S. § 36-2905.03(C)and (D)
88. "Emancipated minor"	R9-22-116
89. "Emergency medical condition"	42 U.S.C. 1396b(v)
90. "Emergency medical services"	R9-22-102
91. "Encounter"	R9-22-107
92. "Enrollment"	R9-22-117
93. "Enumeration"	R9-22-101
94. "Equity"	R9-22-101
95. "Expressly emancipated minor"	R9-22-116
96. "FAA" or "Family Assistance Administration"	R9-22-114
97. "Facility"	R9-22-101
98. "Factor"	R9-22-101
99. "FBR"	R9-22-101
100. "Federal Benefit Rate"	R9-22-101
101. "Federal emergency services program"	R9-22-101
102. "FESP"	R9-22-101
103. "Foster care maintenance payment"	R9-22-114
104. "Foster child"	R9-22-114
105. "FPL"	R9-22-114
106. "FQHC"	R9-22-101
107. "Grievance"	R9-22-108
108. "GSA"	R9-22-101
109. "Guardian"	R9-22-116
110. "Head-of-household"	R9-22-116
111. "Hearing aid"	R9-22-102
112. "Home health services"	R9-22-102
113. "Homebound"	R9-22-114
114. "Hospital"	R9-22-101
115. "Hospitalized"	R9-22-116
116. "ICU"	R9-22-107
117. "IHS"	R9-22-117
118. "Income"	R9-22-114 and R9-22-116
119. "Income-in-kind"	R9-22-116

120. "Indigent" A.R.S. § 11-297
121. "Inmate of a public institution" 42 CFR 435.1009
122. "Interim change" R9-22-116
123. "JTPA" or "Job Training Partnership Act" R9-22-114
124. "License or licensure" R9-22-101
125. "Liquid assets" R9-22-114 and R9-22-116
126. "Liquid resources" R9-22-116
127. "Lump-sum income" R9-22-116
128. "Mailing date" R9-22-114
129. "Medical education costs" R9-22-107
130. "Medical record" R9-22-101
131. "Medical review" R9-22-107
132. "Medical services" R9-22-101
133. "Medical supplies" R9-22-102
134. "Medical support" R9-22-114
135. "Medically necessary" R9-22-101
136. "Medicare claim" R9-22-107
137. "Medicare HMO" R9-22-101
138. "MI/MN" A.R.S. § 36-2901(4)(a) and (c)
139. "Minor parent" R9-22-114
140. "Month of determination" R9-22-116
141. "New hospital" R9-22-107
142. "NICU" R9-22-107
143. "Noncontracting provider" A.R.S. § 36-2931
144. "Nonliquid resources" R9-22-116
145. "Nonparent caretaker relative" R9-22-114
146. "Nursing facility" 42 U.S.C. 1396r(a)
147. "Occupational therapy" R9-22-102
148. "Operating costs" R9-22-107
149. "Outlier" R9-22-107
150. "Outpatient hospital service" R9-22-107
151. "Ownership change" R9-22-107
152. "Peer group" R9-22-107
153. "Pharmaceutical service" R9-22-102
154. "Physical therapy" R9-22-102
155. "Physician" R9-22-102
156. "Practitioner" R9-22-102
157. "Pre-enrollment process" R9-22-114
158. "Prescription" R9-22-102
159. "Primary care provider" R9-22-102
160. "Primary care provider services" R9-22-102
161. "Prior authorization" R9-22-102
162. "Private duty nursing services" R9-22-102
163. "Proposal of discontinuance" R9-22-116
164. "Prospective rate year" R9-22-107
165. "Prospective rates" R9-22-107
166. "Public assistance" R9-22-116
167. "Quality management" R9-22-105
168. "Radiology" R9-22-102
169. "Rebasing" R9-22-107
170. "Recipient" R9-22-114
171. "Redetermination" R9-22-116
172. "Referral" R9-22-101
173. "Rehabilitation services" R9-22-102
174. "Reinsurance" R9-22-107
175. "Resources" R9-22-114 and R9-22-116
176. "Respiratory therapy" R9-22-102
178. "Review" R9-22-114
179. "RFP" R9-22-105
180. "Scope of services" R9-22-102
181. "SDAD" R9-22-107
182. "Separate property" A.R.S §25-213
183. "Service location" R9-22-101
184. "Service site" R9-22-101
185. "SESP" R9-22-101
186. "S.O.B.R.A." R9-22-101
187. "Specialist" R9-22-102
188. "Specified relative" R9-22-114 and R9-22-116
189. "Speech therapy" R9-22-102
190. "Spendthrift restriction" R9-22-114
191. "Spouse" R9-22-101
192. "SSA" P.L. 103-296, Title I
193. "SSI" R9-22-101
194. "SSN" R9-22-101
195. "State alien" R9-22-101
196. "State emergency services program" R9-22-101
197. "Sterilization" R9-22-102
198. "Subcontract" R9-22-101
199. "SVES" or "State Verification and Exchange System" R9-22-114
200. "Tier" R9-22-107
201. "Tiered per diem" R9-22-107
202. "Title IV-A" R9-22-114
203. "Title IV-D" R9-22-114
204. "Title IV-E" R9-22-114
205. "TMA" R9-22-114
206. "Total inpatient hospital days" R9-22-107
207. "Unearned income" R9-22-116
208. "Utilization management" R9-22-105

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person.
2. "Applicant" means a person who submits or whose representative submits, a written, signed, and dated application for AHCCCS benefits that has not been approved or denied.
3. "Application" means an official request for medical assistance made under this Chapter.
4. "Assignment" means enrollment of an eligible person with a contractor by the Administration.
5. "Capped fee-for-service" means the payment mechanism by which providers of care are reimbursed upon submission of valid claims for specific AHCCCS covered services and equipment provided to eligible applicants. Payments are made in accordance with an upper, or capped, limit established by the Director.
6. "Case record" means the file and all documents in the file that are used to establish eligibility.
7. "Categorically eligible" means a person who is eligible as defined by A.R.S. §§ 36-2901(4)(b) and 36-2934.
8. "Continuous stay" means the period of time during which an eligible person receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.
9. "Contract" means a written agreement entered into between a person, organization, or other entity and the Administration, to provide health care services to members under A.R.S. Title 36, Chapter 29, and these rules.
10. "Contractor" means a person, organization, or entity that agrees through a direct contracting relationship with the Administration, to provide goods and services specified by the contract under the requirements of the contract and these rules.

11. "Contractor of record" means the organization or entity in which a person is enrolled for the provision of AHCCCS services.
12. "Day" means a calendar day unless otherwise specified in the text.
13. "DES" means the Department of Economic Security.
14. "EAC" means eligible assistance children.
15. "ELIC" means eligible low income children.
16. "Eligible assistance children" means the children defined by A.R.S. § 36-2905.03(B).
17. "Eligible low income children" means the children defined by A.R.S. § 36-2905.03(C) and (D).
18. "Eligible applicant" means the applicant defined in A.R.S. § 36-2901(4).
19. "Enumeration" means the assignment of a specific 9-digit identification number to a person by the Social Security Administration.
20. "Equity" means the county assessor full cash or market value of a resource minus valid liens, encumbrances, or both.
21. "Facility" means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution, under A.R.S. Title 36, Chapter 4, to provide medical services, nursing services, or other health care or health-related services.
22. "Factor" means an organization, collection agency, service bureau, or person who advances money to a provider for accounts receivable that the provider assigns, sells, or otherwise transfers, including transfers through the use of a power of attorney, to the organization, collection agency, service bureau, or person that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. The term "factor" does not include business representatives, such as billing agents or accounting firms described within these rules, or health care institutions.
23. "FBR" means Federal Benefit Rate, defined in R9-22-101(B)(24).
24. "Federal Benefit Rate" means the maximum monthly Supplemental Security Income payment rate for an eligible person or married couple.
25. "Federal emergency services program" means a program designed to provide emergency medical services covered under 42 U.S.C. 1396b(v), to treat an emergency medical condition for a categorically eligible person who is determined eligible under A.R.S. § 36-2903.03.
26. "FESP" means federal emergency services program.
27. "FQHC" means federally qualified health center.
28. "GSA" means a geographical service area designated by the Administration within which a contractor of record provides, directly or through subcontract, covered health care services to members enrolled with that contractor of record.
29. "Hospital" means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of certification.
30. "Indigent" means meeting eligibility criteria under A.R.S. § 11-297.
31. "Inmate of a public institution" means a person defined by 42 CFR 435.1009.
32. "License" or "licensure" means a nontransferable authorization that is based on established standards in law, is issued by a state or county regulatory agency or board, and allows a health care provider to render a health care service lawfully.
33. "Medical record" means all documents that relate to medical and behavioral health services provided to an eligible person, a physician, or other licensed practitioner of the healing arts or member and that are kept at the site of the provider.
34. "Medical services" means health care services provided to an eligible person by a physician, practitioner, dentist, or by health professionals and technical personnel under the direction of a physician, practitioner, dentist.
35. "Medically necessary" means covered services provided by a physician or other licensed practitioner of the healing arts and within the scope of practice under state law to:
    a. Prevent disease, disability, and other adverse health conditions or their progression; or
    b. Prolong life.
36. "Medicare HMO" means a health maintenance organization that has a current contract with the Health Care Financing Administration (HCFA) for participation in the Medicare program under 42 CFR 417(L).
37. "MI/MN" means medically indigent and medically needy defined in A.R.S § 36-2901(4)(a) and (c).
38. "Nursing facility" means a nursing facility defined in 42 U.S.C. 1396r(a).
39. "Noncontracting provider" means the provider defined in A.R.S. § 36-2931.
40. "Referral" means the process by which an eligible person is directed by a primary care provider or attending physician to another appropriate provider or resource for diagnosis or treatment.
41. "Separate property" means property defined in A.R.S. § 25-213.
42 "Service location" means any location at which a member obtains any health care service provided by the contractor of record under the terms of a contract.
43. "Service site" means a location designated by the contractor of record as the location at which a person is to receive health care services.
44. "SESP" means state emergency services program.
45. "S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988.
46. "Spouse" means the husband or wife who has entered into a contract of marriage, recognized as valid by Arizona.
47. "SSA" means Social Security Administration defined in P.L. 103-296, Title I.
48. "SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.
49. "SSN" means social security number.
50. "State alien" means an unqualified alien described in A.R.S. § 36-2903.03(C).
51. "State emergency services program" means a program designed to provide emergency medical services identified as covered under R9-22-217 to treat an emergency medical condition for a person who is determined eligible under A.R.S. § 36-2905.05.
52. "Subcontract" means an agreement entered into by a contractor with any of the following:

a. A provider of health care services who agrees to furnish covered services to members;

b. A marketing organization; or

c. Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligations to the Administration under the terms of a contract.

~~**R9-22-103. Eligibility and Enrollment Related Definitions**~~

~~In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

1. ~~"AHCCCS disqualified dependent" means a natural or adoptive dependent minor residing in a household with an AHCCCS disqualified spouse.~~
2. ~~"AHCCCS disqualified spouse" means the spouse of an MI/MN or state emergency services applicant, who is ineligible for AHCCCS MI/MN or state emergency services benefits because the spouse's separate property, when combined with other resources owned by all household members, exceeds the allowable resource limit.~~
3. ~~"Case record" means the file and all documents in the file that are used to establish eligibility.~~
4. ~~"Categorically eligible" means a applicant who is eligible as defined by A.R.S. § 36-2901(4)(b).~~
5. ~~"Certification period" means the period of time for which a applicant is certified under A.R.S. § 36-2901(4)(a), (c), (h), and (j) as eligible for AHCCCS benefits.~~
6. ~~"County eligibility worker" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS.~~
7. ~~"Date of application" means the date on which the county eligibility office receives a completed and signed Part I of the AHCCCS application form or receives official notification from a provider of emergency services as specified in Article 3.~~
8. ~~"Date of determination" means the date on which a decision of an applicant's eligibility or ineligibility as an indigent, medically needy applicant, eligible low-income child, or state emergency services applicant is communicated by the county to the applicant by a Notice of Action and, for eligible applicants, to the Administration as specified in 9 A.A.C. 22, Article 3.~~
9. ~~"Deemed date of application" means the 30th day following either the original date of application or a previously deemed date of application. A deemed date of application is established for an untimely application, and replaces the original date of application in determining a household's assets, resources, and income.~~
10. ~~"Dependent child" means an unborn child, an unemancipated minor, or an 18 year old, if all of the following 3 conditions exist:~~
    a. ~~The 18 year old is a full time student in a secondary school, or in a vocational, technical, or trade school that grant credits to be applied toward secondary school graduation;~~
    b. ~~The 18 year old is reasonably expected to graduate before reaching age 19; and~~
    c. ~~The 18 year old resides with 1 or both parents or a specified relative.~~
11. ~~"DES" means the Department of Economic Security.~~
12. ~~"Determination" means the process by which an applicant is approved or denied for coverage as an indigent or medically needy applicant, an eligible low income child, or a state emergency services applicant. Determination includes the decision by the county of an applicant's eligibility or ineligibility, the communication, for eligible applicants, of the decision by the county to the Administration's Notification Unit, and the communication of the decision by the county to the applicant by a Notice of Action.~~
13. ~~"Disenrollment" means the discontinuance of a member's entitlement to receive covered services from a contractor of record.~~
14. ~~"Disqualified household member" means a applicant who is ineligible for indigent, medically needy, eligible low income child, or state emergency services coverage due to a refusal to cooperate with the Title XIX eligibility process as required by state law.~~
15. ~~"Eligible assistance children" means the children defined by A.R.S. § 36-2905.03(B).~~
16. ~~"Eligible low income children" means the children defined by A.R.S. § 36-2905.03(C) and (D).~~
17. ~~"Emancipated minor" means a minor who is married or divorced, in military service, or the subject of a court order declaring the minor to be emancipated.~~
18. ~~"Enrollment" means the process by which an eligible applicant becomes a member of a contractor's plan.~~
19. ~~"Equity" means the full cash or market value of a resource minus valid liens, encumbrances, or both.~~
20. ~~"Expressed emancipated minor" means a minor whose parent has or parents have signed a notarized affidavit indicating that the minor is no longer under parental support and control, and that the parent has or parents have surrendered claim to the state and federal tax dependency deductions provided that the minor is not living with a parent or a specified relative acting as a legal or de facto guardian, and a court has not ordered custody with another applicant or agency.~~
21. ~~"Fair consideration" means money or goods or services that can be valued in terms of money that is received in exchange for property or resources transferred and that has a value equal to at least 80% of the property or resources transferred.~~
22. ~~"Full cash value" means the current value of real properties as determined by the County Assessor's Office for the county in which the real property is located.~~
23. ~~"Gross earnings from employment" means the total payment received by an employee from an employer in exchange for goods or services.~~
24. ~~"Guardian" means a guardian, conservator, executor, or public fiduciary appointed by a court or other protective order to be in charge of the affairs of a minor or incapacitated applicant.~~
25. ~~"Head of household" means the family household member who assumes the responsibility for providing AHCCCS eligibility information for the family household members in accordance with Article 3 of these rules.~~
26. ~~"Incapacitated applicant" means a applicant who is mentally or physically impaired to the extent that the applicant is unable to make or communicate responsible decisions concerning the applicant.~~
27. ~~"Income in kind" means any noncash item or service received by an individual from a applicant or organization.~~

~~28. "Interim change" means either a change occurring after the date of application and before the eligibility decision or a change occurring during the certification period.~~
~~29. "Liquid assets" means all property and resources readily convertible to cash.~~
~~30. "Minor" means a applicant who is less than age 18.~~
~~31. "Open enrollment" means a period of time during which all eligible applicants and members may choose to be enrolled with another available contractor of record.~~
~~32. "Public assistance" means benefits provided to a applicant, either directly or indirectly by a city, county, federal, or state governmental agency, based on financial needs.~~
~~33. "Redetermination" means the process by which an eligible applicant under A.R.S. § 36-2901.4(a), (e), or (h) applies for a new eligibility certification period before expiration of the current certification period.~~
~~34. "Refusal to cooperate" means that a applicant refuses to be interviewed by or fails to provide, upon written request, information or available verification to the county, DES, or Administration's eligibility staff or an eligibility quality control reviewer, or refuses to sign the Intent to Cooperate Form, or fails to keep a scheduled appointment without providing a reasonable explanation, or voluntarily withdraws an application for federal benefits when the an application is required by state law.~~
~~35. "Separate property" means real and personal property of a spouse, owned by the spouse before the marriage, or acquired by gift, devise, or descent after the marriage.~~
~~36. "S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a)(10)(A)(ii)(IX), July 1, 1988.~~
~~37. "SSA" means Social Security Administration as defined in P.L. 103-296, Title I.~~
~~38. "Specified relative" means a nonparent caretaker of a dependent child who is a grandmother, grandfather, sister, brother, stepmother, stepfather, stepbrother, stepsister, aunt, uncle, 1st cousin, niece, nephew, or applicant of preceding generations whose relationship to the child is described by any of these terms preceded by a single "great" or "grand". A specified relative must be at least 18 years old to apply on behalf of a dependent child, unless awarded custody by a court.~~
~~39. "Spend down" means the dollar value of medical expenses that a family household must have incurred and either have paid or remain responsible to pay in order to bring its net annual income within the eligibility income limit.~~
~~40. "Spouse" means the husband or wife of an AHCCCS applicant or household member, who has entered into a contract of marriage, recognized as valid by Arizona.~~
~~41. "SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.~~
~~42. "Untimely application" means an MI/MN application for which the date of determination is later than the 30th day following the date of application or, if the head of the household has agreed in writing to an extension, later than the 60th day following the date of application. For MI/MN S.O.B.R.A. dual applications, if the completed application is submitted to DES within 30 days after the date of application but DES does not determine S.O.B.R.A. eligibility within 30 days after the date of application, the application for those household members for whom S.O.B.R.A. eligibility is being determined is not an untimely application if the date of determination is not later than 10 working days after a determination of S.O.B.R.A. eligibility is made by DES or 20 working days after the application is forwarded to DES, whichever is earlier.~~
~~43. "Work-related expenses" means nonreimbursed expenses related to employment for travel, meals, lodging, uniforms, licenses for employment, union dues, tools, or materials required for employment.~~

R9-22-114. Title IV-A Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "210" means 42 CFR 435.210.
2. "1931" means Section 1931 of the Social Security Act.
3. "Act" means the Social Security Act.
4. "Adequate notice" means a notice that explains the action the Department intends to take, the reason for the action, the specific authority for the action, the recipient's appeal rights, right to medical assistance pending appeal, and that is mailed before the effective date of the action.
5. "Administration" means the AHCCCS Administration.
6. "Adverse action" means an action taken by the Department to deny, discontinue, or reduce medical assistance.
7. "Appellant" means an applicant or recipient of medical assistance who is appealing an adverse action by the Department.
8. "Assistance unit" means a group of persons whose needs, income, and resources are considered as a unit for purposes of determining eligibility for medical assistance.
9. "Authorized representative" means a person who is authorized by the applicant, recipient, or legally responsible person to act on behalf of the applicant or recipient.
10. "Baby Arizona" means the public/private partnership program that provides a pregnant woman an opportunity to apply for medical assistance at a Baby Arizona provider's office through a streamlined eligibility process.
11. "BHS" means Behavioral Health Services, Arizona Department of Health Services.
12. "Bona fide funeral agreement" means a prepaid plan that specifically covers only funeral-related expenses as evidenced by a written contract.
13. "Burial plot" means a space reserved in a cemetery, crypt, vault, or mausoleum for the remains of a deceased person.
14. "Caretaker relative" means a parent or relative who maintains a family setting for a dependent child and who exercises responsibility for the day-to-day physical care, guidance, and support of that child.
15. "Cash assistance" means a program administered by the Department that provides assistance to needy families with dependent children under 42 U.S.C. 601 et seq.
16. "Child welfare agency" means any agency or institution defined in A.R.S. § 8-501(A)(1).
17. "CRS" means Children Rehabilitation Services.
18. "DCSE" means the Division of Child Support Enforcement, which is the division within the Department that administers the Title IV-D program and includes a contract agent operating a child support enforcement program on behalf of the Department.
19. "Department" means the Arizona Department of Economic Security.

20. "Dependent child" means a child defined at A.R.S. § 46-101(7).
21. "District Medical Consultant" means a licensed physician whom the Department employs to review medical records for the purpose of determining physical or mental incapacity.
22. "Eligibility determination date" means the date the Department makes the decision described in R9-22-1414 and issues the eligibility decision notice.
23. "FAA" or "Family Assistance Administration" means the administration within the Department's Division of Benefits and Medical Eligibility with responsibility for providing cash and food stamp assistance to an eligible person and for determining eligibility for medical assistance.
24. "Foster care maintenance payment" means a monetary amount defined in Section 475(4)(A) of the Social Security Act.
25. "Foster child" means a child placed in a foster care setting.
26. "FPL" means the federal poverty level guidelines published annually by the United States Department of Health and Human Services.
27. "Homebound" means a person who is confined to the home because of physical or mental incapacity.
28. "Income" means earned and unearned income combined.
29. "JTPA" or "Job Training Partnership Act" means the program authorized by 29 U.S.C. 1501 et seq. which prepares youth and unskilled adults for entry into the labor force and affords special job training.
30. "Liquid assets" means cash or another financial instrument that is readily convertible to cash.
31. "Mailing date", when used in reference to a document sent 1st class, postage prepaid, through the United States mail, means the date:
    a. Shown on the postmark;
    b. Shown on the postage meter mark of the envelope, if there is no postmark; or
    c. Entered on the document as the date of its completion, if there is no legible postmark or postage meter mark.
32. "Medical support" means an obligation of a natural or adoptive parent to provide health care coverage in the form of health insurance or court-ordered payment for medical care.
33. "Minor parent" means a person meeting the age requirements of R9-22-1401(B)(1) who is also a parent.
34. "Nonparent caretaker relative" means a person, other than a parent, who is related by blood, marriage, or lawful adoption to the dependent child and who maintains a family setting for the dependent child and exercises responsibility for the day to day care of the dependent child.
35. "Pre-enrollment process" means the process that provides an applicant the opportunity to choose an AHCCCS health plan before the determination of eligibility is completed.
36. "Recipient" means a person who is approved for and receiving medical assistance under this Article.
37. "Resources" means real and personal property including liquid assets.
38. "Review" means a review of all factors affecting an assistance unit's eligibility.
39. "Specified relative" means a person defined in R9-22-1418(B).
40. "Spendthrift restriction" means a legal restriction on the use of a resource that prevents a payer or beneficiary from alienating the resource.
41. "SVES" or "State Verification and Exchange System" means a system through which the Department exchanges income and benefit information with the Internal Revenue Service, Social Security Administration, State Wage, and Unemployment Insurance Benefit data files.
42. "Title IV-A" means the relevant provisions, specified in Section 1931 of the Social Security Act, of the Aid to Families With Dependent Children program that was in place in the state's Title IV-A State Plan as of July 1996.
43. "Title IV-D" of the Social Security Act means 42 U.S.C. 651-669, the statutes establishing the child support enforcement and establishment of paternity program.
44. "Title IV-E" of the Social Security Act means 42 U.S.C. 670-679, the statutes establishing the foster care and adoption assistance programs.
45. "TMA" means Transitional Medical Assistance.

R9-22-115. SSI MAO Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Aged" means a person who is 65 years of age or older, specified in 42 U.S.C. 1382c(a)(1)(A).
2. "Blind" means a person who has been determined blind by the Department of Economic Security, Disability Determination Services Administration, under with 42 U.S.C. 1382c(a)(2).
3. "Certification period" means the period of time, not to exceed 6 months, during which a person who is eligible for FESP is anticipated to require emergency services.
4. "Disabled" means a person who has been determined disabled by the Department of Economic Security, Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E).

R9-22-116. State-Only Eligibility Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "1-time income" means income that a person may receive only once. Examples are:
    a. The total of gifts received during the 3-month income period for a birthday, wedding, anniversary, graduation, religious event, or birth;
    b. The total of single payment death benefits; or
    c. The total of single payment insurance or legal settlements resulting from 1 accident.
2. "3-month income period" means the 91 or 92 days immediately preceding the application date. The 3-month income period is 92 days only if:
    a. A household member regularly receives a monthly or 2-time-a-month payment; and
    b. The household member received the 3rd of 3 monthly payments on the 92nd day preceding the application date; or
    c. The household member received the 6th of 6 2-time-a-month payments, on the 92nd day preceding the application date.
3. "Certification period" means the period of time for which a person is certified under A.R.S. § 36-

2901(4)(a), (c), (h), and (j) as eligible for AHCCCS benefits.

4. "Countable income" means gross income, less amounts that are disregarded under R9-22-1626(D) and amounts that are deducted under R9-22-1626(E).
5. "County eligibility staff" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS or conduct related business.
6. "Date of determination" means the date on which a decision of an applicant's eligibility or ineligibility as a medically indigent, medically needy person, eligible low income child, or state emergency services person is communicated by the county to the applicant by a Notice of Action and, for eligible applicants, to the Administration as specified in R9-22-1618.
7. "Date of discontinuance" means the last day of MI/MN, ELIC, SESP, or EAC coverage when there is a discontinuance.
8. "Deductible medical expense" means the cost of:
   a. A medically necessary service or supply that would be covered if provided to an AHCCCS member of any age under 9 A.A.C. 22, Article 2 and 9 A.A.C. 22, Article 12;
   b. A medically necessary service or supply that would be covered if provided to an ALTCS member under 9 A.A.C. 28, Article 2 and 9 A.A.C. 28, Article 11;
   c. Other medically necessary services that are provided by a licensed practitioner or physician;
   d. Assistance with daily living provided under prescription by a licensed physician or practitioner except when provided by the spouse of a patient or the parent of a minor patient;
   e. Care in a licensed nursing home, supervisory care facility, adult foster home, or in another residential care facility licensed by the Arizona Department of Health Services;
   f. Purchasing and maintaining a dog guide or service dog for the assistance of the applicant or member; or
   g. Health insurance premiums if the insured is a household member.
9. "Deemed application date" means the 30th day following either the original application date or a previously deemed application date, whichever is later.
10. "Dependent child" means an unborn child, an unemancipated minor, or an 18-year-old, if all of the following 3 conditions exist:
    a. The 18-year-old is a full-time student in a secondary school, or in a vocational, technical, or trade school that grant credits to be applied toward secondary school graduation;
    b. The 18-year-old is reasonably expected to graduate before reaching age 19; and
    c. The 18-year-old resides with 1 or both parents or a specified relative.
11. "Determination" means the process by which an applicant is approved or denied for coverage as an indigent or medically needy person, an eligible low-income child, or a state emergency services applicant.
12. "Discontinuance" means an action taken by county eligibility staff or the Administration to terminate a person's eligibility under MI/MN, ELIC, or SESP.
13. "Earned income" means money or its equivalent received by a household member in exchange for:
    a. Labor;
    b. Professional service or entrepreneurship, including income from the rental of real or personal property;
    c. Vacation pay;
    d. Sick pay;
    e. Tips; and
    f. Gratuities.
14. "Educational income" means income received as a scholarship or grant by a student for the purpose of paying tuition, fees, and related expenses, excluding room and board expenses.
15. "Emancipated minor" means a minor who is married or divorced, in military service, or the subject of a court order declaring the minor to be emancipated.
16. "Expressly emancipated minor" means a minor whose parent has or parents have signed a notarized affidavit indicating that the minor is no longer under parental support and control, and that the parent has or parents have surrendered claim to the state and federal tax dependency deductions provided that the minor is not living with a parent or a specified relative who is the legal guardian or acting as guardian, and a court has not ordered custody with another person or agency.
17. "Guardian" means a guardian, conservator, executor, or public fiduciary appointed by a court or other protective order to manage the affairs of a minor or incapacitated person.
18. "Head-of-household" means the family household member who assumes the responsibility for providing AHCCCS eligibility information for the family household members under 9 A.A.C. 22, Article 16.
19. "Hospitalized" means in a hospital as an inpatient at the time of application or at any time from the application date through the date of determination.
20. "Income" means money or other liquid resource that:
    a. Is received or deemed received by a person under R9-22-1626(C);
    b. Becomes available for a person's legal unrestricted use;
    c. Is used by a person; or
    d. Is due to a person but paid to someone else on the person's behalf, including monies paid from a trust to which the person is a beneficiary if the trust is excluded as a resource.
21. "Income-in-kind" means any noncash item or service received that is not deducted from other income to which the recipient is entitled.
22. "Interim change" means either a change occurring after the application date and before the eligibility decision or a change occurring during the certification period.
23. "Liquid assets" means all property and resources readily convertible to cash.
24. "Liquid resources" means liquid assets.
25. "Lump-sum income" means income received in a single payment instead of regularly occurring installments over a period of time.
26. "Month of determination" means the calendar month during which the date of determination occurs.
27. "Nonliquid resources" means all resources that are not readily convertible to cash.
28. "Proposal of discontinuance" means a notice sent to a person informing the person that AHCCCS benefits will terminate on a specified date unless the person provides proof of eligibility within 15 days following the date of the notice.

29. "Public assistance" means benefits provided to a person, either directly or indirectly by a city, county, state, federal, or governmental agency, based on financial needs.
30. "Redetermination" means the process by which an eligible person under A.R.S. §§ 36-2901.4(a), (c), or (h) applies for a new eligibility certification period before expiration of the current certification period.
31. "Resources" means property of any kind, real or personal, that can be converted to food, clothing, shelter, medical care, or money.
32. "Specified relative" means a nonparent caretaker of a dependent child who is a grandmother, grandfather, sister, brother, stepmother, stepfather, stepbrother, stepsister, aunt, uncle, 1st cousin, niece, nephew, or person of preceding generations whose relationship to the child is described by any of these terms preceded by a single "great" or "grand". A specified relative shall be at least 18 years old to apply on behalf of a dependent child, unless a court has awarded custody of the dependent child to the specified relative.
33. "Unearned income" means all income defined in subsection (20) except income which is defined as earned income in subsection (11).

R9-22-117. Enrollment Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "AEC" means Annual enrollment choice.
2. "Annual enrollment choice" means the annual opportunity for a person to change contractors.
3. "Auto-assignment algorithm" means the mathematical formula used by the Administration to assign persons to the various contractors.
4. "CMDP" means Comprehensive Medical and Dental Services.
5. "Date of enrollment action" means the date the Administration processes an enrollment action on a person's enrollment record.
6. "Disenrollment" means the discontinuance of a person's entitlement to receive covered services from a contractor of record.
7. "Enrollment" means the process by which an eligible person becomes a member of a contractor's plan.
8. "IHS" means Indian Health Services.

~~**ARTICLE 3. ELIGIBILITY AND ENROLLMENT**~~

~~**R9-22-301. Residency Requirements for Indigent and Medically Needy Applicants and Eligible Low-income Children**~~

~~A. All AHCCCS members shall be residents of Arizona and have abandoned residence outside of Arizona. Arizona residency shall be established by each applicant in the family household by meeting the requirements of this Section.~~

~~B. The head-of-household, spouse or other parent shall provide any one of the following documents issued in the name of the head-of-household, the name of the spouse or the name of the other parent, if the spouse or other parent resides with the head-of-household.~~

~~1. An Arizona rent or mortgage receipt or utility bill issued during the month of application or issued the month immediately prior to or immediately following the month of application.~~
~~2. An unexpired Arizona motor vehicle operator's license.~~
~~3. A current Arizona vehicle registration issued within 12 months from the date of application.~~
~~4. A document issued within 30 days of presentation showing present employment in Arizona or a document showing acceptance of employment in Arizona.~~
~~5. A document showing that the dependent child(ren) has been enrolled in an Arizona school for the current school year or for the subsequent school year.~~
~~6. Evidence or receipt of public assistance in Arizona issued within 13 weeks prior to date of application or within 30 days prior to date of determination.~~
~~7. Evidence of Arizona registration to vote.~~
~~8. A document not more than 30 days old indicating registration with a public or private employment service located in Arizona.~~

~~C. The residency of other family household applicants shall be considered verified when the head of household or spouse's residency is verified unless the eligibility worker has reason to question the applicant's residency.~~

~~1. If a dependent child's presence in the home is in question, the eligibility worker shall record in the case record why it is questioned and how it was resolved. Methods of resolving a dependent child's residency that is questionable shall be established by obtaining third party documented or collateral statements including, but not limited to, school enrollment verification.~~
~~2. If the eligibility worker receives information which causes the residency of an adult or emancipated minor included in the family household to be questionable, the applicant in question shall be required to provide the information identified in subsections (B), (D), and (E), if necessary, to establish residency.~~
~~3. If a dependent child is living with a parent or specified relative who is not eligible as an indigent or medically needy applicant, residency for the dependent child shall be established when the head of household requirements in this Section have been met by the parent or specified relative.~~

~~D. The head of household or spouse shall sign an affidavit, in the presence of the county eligibility worker, attesting that all of the following are true for all individuals included in the family household.~~

~~1. That none of the family household applicants own or lease property as a residence or otherwise maintain a residence outside the state of Arizona.~~
~~2. That none of the family household applicants own or lease a motor vehicle currently registered outside the state of Arizona.~~
~~3. That none of the family household applicants are currently receiving public assistance or Title XIX benefits outside the state of Arizona. Public assistance does not include Unemployment Insurance benefits.~~
~~4. That all adult family household applicants are actively seeking employment in Arizona if they are unemployed and if they are able to work.~~
~~5. That all family household applicants are living in Arizona and intend to remain indefinitely in Arizona.~~

~~E. If the requirements specified in subsections (B) and (D) cannot be provided by the head of household, spouse, or designated representative, or if the applicant has moved to Arizona within the six month period immediately preceding the date of application for the purpose of receiving AHCCCS benefits, the county eligibility worker shall refer the application to the special eligibility officer.~~

~~1. The special eligibility officer shall be an individual appointed by the County Board of Supervisors.~~

2. The special eligibility officer shall receive third party evidence and shall make inquiries as necessary to determine whether the applicant or member is an Arizona resident.
3. A determination of residency shall not be made unless a preponderance of credible evidence establishes that the applicant or household member intends to remain in Arizona indefinitely and is either physically present in Arizona or is temporarily absent from this state and hospitalized at the time of application, and that the applicant has abandoned residency outside of Arizona.
4. If the evidence presented does not support residency of all applicants in the family household, the nonresident family household member shall be denied eligibility or benefits shall be discontinued.
5. If the applicant has moved to Arizona within the six-month period immediately preceding the date of application for the purpose of receiving AHCCCS benefits, the applicant shall produce one of the required documents and sign the affidavit. The special eligibility officer also shall accept any additional proof of residency offered by the applicant and shall inquire into any facts relevant to the question of residency.
6. The special eligibility officer shall not make a determination of residency based solely upon the statement of truth or a statement of intent and shall require collateral verification of residency.

F. The head of household or spouse shall be given 30 days from date of application to meet the requirements of this Section unless otherwise determined ineligible. The time can be extended 30 days pursuant to R9-22-313(D).

G. The Statement of Truth, a statement of residency or a notarized statement signed by the head of household or spouse shall not by itself verify Arizona residence.

H. The head of household or spouse shall confirm his or her county of residency by providing third party documented or collateral evidence of his or her residential address.

I. The documents or copy of the documents used to verify residency as specified in (B), (C), (D), (E), and (H) of this Section shall be filed in the case record. The signed affidavit, referred to in (D) of this Section, shall be filed in the case record. If referred to the special eligibility officer as specified in (E) of this Section, all supporting documents and a record explaining how the decision was reached shall be filed in the case record.

J. The eligibility worker shall verify residency at the following times.
1. Prior to approving an initial application.
2. Prior to approving a reapplication if there has been a break in AHCCCS coverage or if residency has not previously been established in accordance with the requirements of R9-22-301.
3. Prior to approving a priority application pursuant to R9-22-308.
4. Any time there is reason to question residency for any AHCCCS family household member.
5. Prior to adding a household member, the county shall determine Arizona residency for the additional household member. The case record shall indicate that residency was discussed with the head of household or spouse and how residency for that member was established. If the head of household's residency has not been previously established in accordance with the conditions in subsections (B) and (D), or (E) if applicable, these requirements must be satisfied for the head of household or spouse prior to approving the additional members.

K. Verification of residency is not needed prior to a redetermination or interim change when residency has already been established for all family household members according to the rules of this Section, and the eligibility worker has no reason to question residency. The worker shall make reference to the residency documents in the case record and shall indicate in the case record that there has been no change since residency was last verified. In this case, no other verification of residency is necessary.

L. Temporary absence from the state.
1. After meeting the requirements of this Section, a applicant shall continue to be considered an Arizona resident if the applicant is outside the state for a temporary period of not more than 60 consecutive days.
2. To be considered temporarily absent, the applicant shall not abandon or give up the applicant's Arizona residency.
3. The applicant's state-linked activities such as motor vehicle registration, income tax filing, voter registration, or receipt of public assistance must remain Arizona-based during a period of temporary absence.
4. Recipients shall report in advance to the county eligibility office absences from the state which are expected to last more than 60 consecutive days.
5. If the county receives information indicating that the family household or a member of the family household has abandoned Arizona residency, the county shall send a discontinuance notice to the last known address of the head of household to discontinue benefits for the affected member. If Arizona residency is established by the head of household prior to the effective date of the discontinuance, benefits shall continue. If residency is not established prior to the effective date of the discontinuance, benefits shall be discontinued unless the action is appealed as specified in Article 8.

R9-22-302. Citizens and Aliens

No applicant shall be approved for coverage as an indigent or medically needy applicant or eligible low-income child unless that applicant is a citizen of the United States or meets the alienage requirements pursuant to 42 CFR 435.406(a), March 14, 1991, incorporated by reference herein and on file with the Office of the Secretary of State.

R9-22-303. Application and eligibility determination process for the categorically eligible and eligible assistance children

A. AHCCCS eligibility for eligible assistance children and categorically eligible individuals other than SSI recipients shall be determined by the Arizona Department of Economic Security.

B. AHCCCS eligibility for eligible assistance children shall begin on the date that notification of eligibility from the Department of Economic Security is received by the AHCCCS Administration. Enrollment shall be conducted pursuant to R9-22-333.

C. AHCCCS eligibility for all SSI recipients shall be determined by the Social Security Administration.

D. Except as specified in R9-22-304, AHCCCS eligibility for AFDC and SSI recipients shall begin on the first day of the month of application. SSI recipients relocating to Arizona shall be AHCCCS eligible immediately following termination of Title XIX coverage from the recipient's prior state of residence.

~~**R9-22-304. Retroactive coverage for the categorically eligible**~~

~~**A.** Retroactive coverage for AHCCCS covered services shall be provided to categorically eligible individuals for up to three months prior to the first day of the month of application providing:~~

~~1. The individual received covered services during the 3-month period, and~~

~~2. The individual would have been categorically eligible had he or she applied at the time the services were received. Retroactive coverage is not provided for any period prior to October 1, 1982.~~

~~**B.** The Arizona Department of Economic Security shall determine when a categorically eligible applicant is eligible for retroactive coverage.~~

~~**R9-22-305. Redeterminations for the categorically eligible and eligible assistance children**~~

~~**A.** All redeterminations of AHCCCS eligibility for eligible assistance children and categorically eligible individuals other than SSI recipients shall be performed by the Arizona Department of Economic Security.~~

~~**B.** All redeterminations of AHCCCS eligibility for SSI recipients shall be performed by the Social Security Administration.~~

~~**R9-22-306. Initiating the Routine and Priority Application for Indigent and Medically Needy Applicants and Eligible Low-income Children**~~

~~**A.** Any applicant who desires AHCCCS coverage shall be given unrestricted opportunity to apply. The head of household or individual as designated in subsection (B) shall submit the application at the county eligibility office located in the applicant's county of physical residence, except for priority applications as provided in R9-22-308. The head of household shall not be denied the right to submit a completed, signed, and dated Part I Application or to receive assistance as specified in subsections (F) and (G) at any visit to the county eligibility office during normal working hours.~~

~~**B.** The following individuals shall apply concurrently for coverage under Title XIX and coverage as indigent or medically needy applicants or as eligible low-income children.~~

~~1. S.O.B.R.A. age children or pregnant women. If a member of the household is potentially eligible for S.O.B.R.A., an MI/MN/ELIC/S.O.B.R.A. application shall be completed by the county eligibility worker. Applicants who are potentially eligible for coverage under S.O.B.R.A. shall be determined ineligible for S.O.B.R.A. prior to certification or recertification as indigent or medically needy applicants or as eligible low-income children, subject to the provisions of R9-22-309, unless hospitalized at the time of application.~~

~~2. Hospitalized household members who are potentially eligible for Title XIX eligibility. If a hospitalized household member is potentially eligible for a Title XIX eligibility category, that applicant, or the applicant's parent, guardian, or representative, shall initiate a Title XIX application in the county office. The county shall forward the appropriate application to DES in accordance with R9-22-315(B) through (E).~~

~~**C.** A designated representative may complete and sign the AHCCCS application forms on behalf of the head of household if the head of household is unable to initiate an application. The designated representative shall fulfill all the requirements as specified for the head of household in this Article. A designated representative shall be one of the following:~~

~~1. A applicant appointed by a Tribal Court or through protective proceedings as defined in A.R.S. Title 14, Chapter 5, or the applicant's guardian, conservator or executor. If a court has established a legal representative for an individual, the application shall be completed by the legal representative and not the applicant.~~

~~2. A representative authorized in writing by the applicant.~~

~~3. A applicant who has knowledge of the family circumstances if the head of household is deceased or incapacitated and has no spouse, or if the spouse is also incapacitated and the head of household has no conservator, guardian, executor, or agency having legal responsibility. Incapacity shall be verified by written documentation signed by a licensed physician, physician assistant, nurse practitioner, or a registered nurse under the direction of a licensed physician.~~

~~4. A categorical parent or categorical specified relative who is not an applicant because of his or her categorical status.~~

~~5. The head of household's spouse, if they are a one family household or share a common residence.~~

~~6. A parent or specified relative who is ineligible for coverage as an indigent or medically needy applicant because the applicant does not meet the citizenship alien status requirements for that coverage.~~

~~**D.** A medical care facility rendering emergency care to potential AHCCCS members may initiate a priority AHCCCS application by meeting the requirements as specified in R9-22-308.~~

~~**E.** The routine application process is initiated by submission of a completed, dated, and signed Part I Application to the county eligibility office within the head of household's county of physical residence unless the priority application is initiated as specified in R9-22-308. The county eligibility worker shall assist individuals who are required to complete a S.O.B.R.A. application.~~

~~**F.** Any individual may request a Part I Application from the county eligibility office either in applicant, through the mail, or by telephone. The county eligibility office shall ask each applicant who inquires either in applicant or by telephone, about the AHCCCS program the following question: "Do you want to apply for AHCCCS?" If the response is affirmative, the county office shall mail the Part I Application within three working days of the receipt of the telephone or mail request or, if the request is in applicant, the county shall immediately provide the applicant with a Part I Application.~~

~~**G.** The eligibility worker or an individual authorized by the county eligibility office shall assist the head of household in completing the Part I Application when requested to do so by the individual submitting the Part I Application. If the head of household or spouse requests that the county complete the Part I Application, the county shall annotate this request on the application and complete the Part I Application.~~

~~**H.** The county eligibility office shall provide sufficient space and materials for the head of household to complete the Part I Application.~~

~~**I.** Completed, dated, and signed Part I Applications shall be accepted and date stamped or dated manually by the county eligibility office at the time the head of household submits either in applicant or by mail the completed Part I Application to the county eligibility office. The stamped or manually written date shall be the current date and is the date of application. County eligibility offices receiving official notification from a provider or institution providing emergency~~

services as specified in R9-22-308 shall consider the date the call is received as the date of application.

J. The county eligibility office shall provide the head of household with a copy of the accepted and dated stamped Part I Application within three days of receipt of the Part I Application.

K. At the time the Part I Application is submitted to the county office, the county eligibility office shall schedule an appointment with the head of household for the face-to-face interview.

L. If the completed Part I Application is received by mail the county eligibility office shall attempt to contact the head of household either by telephone or by mail within three working days of receipt of the Part I Application to schedule a face-to-face interview. An application received by mail shall not be denied for failure to complete the face-to-face interview unless at least two attempts, occurring on different days, to schedule the interview have been made, one of which must be in writing. Documentation of attempts to schedule the interview shall be recorded in the case record.

M. When someone other than the head of household completes and signs the Part I Application or Part II Application, the case record must contain verification that the representative is qualified to apply on the household's behalf in accordance with R9-22-306(B).

N. Applications filed by applicants who do not meet the criteria of head of household or designated representative shall be denied.

O. In any case in which the household is denied indigent or medically needy eligibility based upon income criteria and the household contains children under the age specified in A.R.S. § 36-2905.03, the county eligibility office shall process the application to determine low-income children eligibility.

R9-22-307. AHCCCS Family Household and Relationship for Indigent and Medically Needy Applicants and Eligible Low-income Children

A. For the purposes of AHCCCS eligibility, the applicants listed in subsection (B) shall be included on 1 AHCCCS application and shall be considered 1 family household. Except as indicated in subsections (D), (E), and (F), applicants included in the family household shall reside in 1 common residence. The head of household shall identify all applicants sharing the common residence. The eligibility worker shall record this information in the case record and shall then establish the AHCCCS family household in accordance with this Section.

1. Except as provided by A.R.S. §§ 11-297, 36-2905, or 36-2905.03, categorically eligible applicants shall not be considered part of the indigent, medically needy, eligible low-income children, or state emergency services family household, unless such applicants are applicants for eligibility as indigent or medically needy applicants, as eligible low-income children, or as state emergency services applicants.
2. AHCCCS disqualified spouses, AHCCCS disqualified dependents, disqualified household members, and Medicare beneficiaries described in R9-22-344 shall be considered part of the indigent, medically needy, eligible low-income children, or state emergency services household.
3. Household members who do not meet the citizenship-alien status requirements for eligibility as indigent or medically needy applicants or eligible low-income children shall be considered part of the indigent, medically needy, or eligible low-income children household.
4. When categorically eligible applicants and disqualified applicants are considered part of the indigent, medically needy, or eligible low-income children household, such applicants shall not be certified eligible as indigent or medically needy or as eligible low-income children under these provisions.
5. When Medicare beneficiaries described in R9-22-344 are considered part of the indigent, medically needy, eligible low-income or state emergency services household, such applicants shall not be certified eligible as indigent or medically needy under these provisions.

B. A family household shall consist of:

1. All married couples, regardless of age, living together without dependent children.
2. All married couples and their natural or adopted dependent children; all natural and adopted children of a natural or adoptive dependent child(ren) of either one or both spouses.
3. A married individual without dependent children and not living with spouse. Natural or adoptive parents or specified relatives shall not be considered part of this family household.
4. A married individual not living with his or her spouse; and his or her natural or adopted dependent children and any children of a natural or adopted dependent children and any children of a natural or adopted dependent child. Natural or adoptive parents or specified relatives shall not be considered as part of this family household.
5. A separated or divorced individual without dependent children. Natural or adoptive parents or specified relatives shall not be considered as part of this family household.
6. A divorced or separated individual, and his or her natural or adopted dependent children and any children of a natural or adopted dependent child. Natural or adoptive parents or specified relatives shall not be considered as part of the family household.
7. An unmarried adult or emancipated minor without any dependent children.
8. An unmarried adult(s) or emancipated minor and his or her or their natural or adopted dependent children and any children of the natural or adopted dependent child. Unmarried applicants without common dependent children shall be a separate AHCCCS family household, except when there is a pregnancy and a common dependent child is expected.
9. A specified relative and the dependent children who live together in one common residence. A dependent child shall be considered on the application of the specified relative.
10. An unemancipated minor child placed with a Foster Parent by a Native American Tribal Court, by a Native American Tribal Agency or by the state of Arizona Department of Economic Security.
11. An unwed minor parent and his or her child(ren) when the unwed minor parent resides alone or with applicants not legally responsible for the support of the minor parent and his or her child(ren). When there is a pregnancy and a common dependent child is expected, both parents shall be considered one household.
12. A pregnant woman and her unborn child, and the father of the unborn child if he is living with the pregnant woman.

C. For households including low-income children, the family household is the same as for the indigent or medically needy;

the family household must meet all eligibility requirements but only the eligible children under age six may be approved for eligibility.

D. A dependent child, absent from the home because of Arizona school attendance or because of residing in an Arizona residential facility shall be considered a member of the family household unless the school or facility is located out of state or the dependent child is residing with the other parent. If the child is residing with the other parent, the child shall be included on the application of the parent with whom the child resides.

E. Spouses separated solely because one is residing in a licensed nursing care institution, licensed supervisory care facility, or certified adult foster care facility, because of a mental or physical disabling condition verified by doctor's orders, shall apply together as one family household on a single AHCCCS application.

F. Spouses separated solely because one is absent temporarily because of remote employment, or because one is seeking remote employment, shall apply together as one family household on a single AHCCCS application.

G. Unless otherwise specified in this Section, a minor who is not emancipated or expressly emancipated shall only be approved for AHCCCS on an application submitted by:

1. Parents,
2. Specified relative,
3. Legal guardian,
4. Authorized agency appointed through court proceedings as established by A.R.S. § 8-538, et seq.
5. A Foster Parent duly appointed by a Native American Tribal Court, a Native American Tribal Agency, the Superior Court of the state of Arizona or the state of Arizona Department of Economic Security, or
6. An unwed minor parent of dependent child(ren) residing alone or with applicants not legally responsible for the support of the minor parent. In such case, the unwed minor parent and his or her child(ren) shall be considered the household for purposes of AHCCCS eligibility.

H. Household composition shall be established and relationship, categorical status, and emancipation status of family household members shall be verified prior to the eligibility determination or at an interim change according to requirements specified in R9-22-327.

I. A family household member defined in subsection (A) of this Section shall not be voluntarily excluded from the AHCCCS family household.

J. Procedures relating to deaths.

1. If an applicant who is the head of household dies before the application is approved, the county shall make reasonable efforts to establish the eligibility of the deceased applicant no later than one day following the date of death. If there is insufficient information to render a decision within this time period, or if the applicant's death is not known to the county until after this date, the application for the deceased applicant shall be denied. If other household members were included on the application, the application shall be denied and a new head of household designated. If Part I of the application is filed by the new head of household within 30 days from the original date of application and the only change in the household composition is the exclusion of the deceased member, the original application date shall be used if the new head of household so elects.
2. If the head of household dies after the application has been approved, the entire household shall be discontinued. Coverage may be continued for the remaining household members if the new head of household files an application. The county shall make reasonable efforts to re-establish eligibility for the remaining household members so there is no break in coverage.
3. If a member of the household dies, the county shall discontinue the deceased member and evaluate the effect of the change in household composition on the remaining household members.

K. The following applicants are not eligible for AHCCCS under this Article:

1. Applicants who are inmates of a public institution;
2. Inmates of a public mental hospital;
3. Recipients of Title XIX (Medicaid) coverage through the state of Arizona or some other state or territory;
4. Minors whose applications were not filed in accordance with subsection (F);
5. Applicants who do not meet the criteria of an AHCCCS family household as defined in subsection (A);
6. Deceased applicants, except as defined in subsection (K);
7. AHCCCS disqualified household members;
8. AHCCCS disqualified spouses;
9. Disqualified household members;
10. Except as provided under R9-22-343, applicants who are not citizens of the United States and who do not meet the alienage requirements pursuant to 42 CFR 435.406(a), March 14, 1991, incorporated by reference and on file with the Office of the Secretary of State.
11. Medicare beneficiaries described in R9-22-344.

R9-22-308. Notification Requirements in Cases of Applicants Receiving Medical Care

A. If an applicant notifies the county that she is pregnant, the county shall have her complete the S.O.B.R.A. application specified in R9-22-309(A). The county then shall complete the eligibility determination of the case under a priority application process defined in R9-22-309(C).

B. Providers of services furnishing care to applicants who have been or are to be hospitalized and whose AHCCCS membership or eligibility is not known shall contact the Administration. If the Administration determines that the applicant is enrolled in an AHCCCS plan, the provider shall notify the applicant's contractor of record within 12 hours from the time of presentation for treatment. If the Administration determines that a applicant is not eligible for indigent, medically needy, or eligible low income child coverage, and the provider has reason to believe that the applicant may be eligible, the provider shall officially notify the county eligibility office in the applicant's county of residence. If the provider notifies the county during the time that the applicant is hospitalized or receiving medical services, the notification shall be considered a priority application. The county shall screen for the hospitalized applicant's potential eligibility for Title XIX, including federal emergency services. The date of notification is the date of application. Official notification to county eligibility offices shall include:

1. Name, address, Social Security number, if available, and the telephone number, if available, of the individual who received care. If the individual is a child, the name, the address, and the telephone number, if available, of the child's parent or responsible adult.
2. Name and address of the facility where treatment was rendered.
3. Present physical location of the individual who received care, if available.

4. Date and time of admission or initiation of treatment.
5. Description of the diagnosis, in layman's terms, of initial diagnosis, accident, or illness which resulted in the hospitalization.
6. Date and time of county notification.
7. Name and telephone number of individual providing the notification.
8. The expected duration of the medical treatment requiring hospitalization, if applicable.
9. Third party liability information, if known.

C. If the institution providing services is notified by the county eligibility office that the individual's eligibility may be dependent upon incurred medical expenses, the institution shall make reasonable efforts to provide the county with timely information regarding billed charges including information regarding any third party liability.

D. The information listed in subsection (B) of this Section shall be recorded in the case record.

E. Only applications initiated by providers of services in accordance with this Section shall be identified as priority applications.

R9-22-309. Completing the Application for Indigent and Medically Needy Applicants, Eligible Low-income Children, and State Emergency Services Applicants

A. The routine AHCCCS application shall be considered complete when:
1. The county has received a completed, signed, and dated Part I Application according to R9-22-306 and it has been filed in the case record; and
2. The Title XIX eligibility screen has been completed; and
3. The head of household completes the Part II Application form. If the head of household or spouse requests that the county complete the Part II Application, the county shall annotate this request on the application and complete the Part II Application. The county shall not have the applicant sign a Part II Application that does not have the applicant's response to each question. Unless the applicant signs and dates any additional entry, the county shall not add information to the sections provided for the applicant's response after the form has been signed by the applicant. Completion of the Part II Application includes:
   a. Each question answered by the applicant and the applicant's response recorded in the section provided;
   b. The form signed and dated by the head of household;
   c. The form signed and dated by the eligibility worker after the worker has made an eligibility decision; and;
   d. The form filed in the case record.
4. The county eligibility worker completes a face-to-face interview in accordance with R9-22-310; and
5. All information needed to determine eligibility has been verified and documented in the case file in accordance with R9-22-327; and
6. The head of household signs the Statement of Truth; and
7. A child or pregnant woman who is potentially eligible for S.O.B.R.A. cooperates with the S.O.B.R.A. eligibility process; and
   a. DES determines the eligibility of the child or pregnant woman for S.O.B.R.A.; or
   b. DES fails to determine if the child or pregnant woman is eligible for S.O.B.R.A. within ten working days from the date DES receives a completed S.O.B.R.A. application together with all necessary verification in support of the application; and
8. A applicant applying for state emergency services who is potentially eligible for federal emergency services cooperates with the federal emergency services eligibility process, and DES determines the applicant is ineligible for federal emergency services; and
9. The county has made a decision that the applicant is eligible or ineligible; and
10. The county eligibility worker has evaluated existing case record information. The evaluation shall compare current application information with existing case information to identify inconsistencies and to determine their effect on the new eligibility determination. The case record shall demonstrate this evaluation; and
11. If eligible, the Administration has been notified according to R9-22-334 of each eligible family household member; and
12. The notice of eligibility or ineligibility has been sent to the head of household.

B. An application to add a member to a household shall be considered complete when:
1. The county has received and filed in the case record a completed, signed, and dated Part I Application in accordance with R9-22-306; and
2. The Title XIX eligibility screen has been completed; and
3. The head of household has provided a written and signed declaration of the additional member's citizenship or alien status, relationship, categorical status, emancipation status, residency, income, and resources, including property transferred within the three years prior to the application date, and this declaration has been filed in the case record; and
4. All information needed to determine eligibility for the household has been verified in accordance with R9-22-327; and
5. If the additional household member is a pregnant woman or S.O.B.R.A. age child, a S.O.B.R.A. decision has been completed by DES in accordance with subsection (A)(7); and
6. If the additional household member is an applicant for state emergency services, a decision has been completed by DES in accordance with subsection (A)(8); and
7. The county has evaluated the effect of the additional member on the household's eligibility; and
8. The county eligibility worker has evaluated existing case record information. The evaluation shall compare current application information with existing case information to identify inconsistencies and to determine their effect on the new eligibility determination. The case record shall demonstrate this evaluation; and;
9. The county has made a decision that the applicant is eligible or ineligible; and
10. If eligible, the Administration has been notified according to R9-22-334 and
11. The notice of eligibility or ineligibility has been sent to the head of the household.

C. A priority AHCCCS application shall be considered complete when:
1. The county has been officially notified in accordance with R9-22-308; and

2. The Part I and Part II Application forms have been completed in accordance with subsection (A)(1) and (2); the Title XIX eligibility screen has been completed; and
3. The Title XIX application has been completed on behalf of the hospitalized household member who is potentially eligible for Title XIX; and
4. The Intent to Cooperate form has been signed by the head of the household; and
5. Except as provided in subsections (D) and (E) of this Section, the county eligibility worker completes a face-to-face interview as required in R9-22-310; and
6. All information needed to determine eligibility has been received and verified in accordance with this Article; and
7. The county eligibility worker has evaluated existing case record information. The evaluation shall compare current application information with existing case information to identify inconsistencies and to determine their effect on the new eligibility determination. The case record shall demonstrate this evaluation; and
8. The county has made a decision that the family household is eligible or ineligible; and
9. If eligible, the AHCCCS Administration has been notified according to R9-22-334 of all eligible family household members; and
10. The notice of eligibility or ineligibility has been sent to the head of household.
11. A child or pregnant woman who is potentially eligible for S.O.B.R.A. is admitted to a hospital as an inpatient at any time while the application is pending. As long as the applicant cooperates with the S.O.B.R.A. application process, the county may certify the applicant as an indigent or medically needy individual or low income child, pending a S.O.B.R.A. eligibility determination by DES.
12. An applicant for state emergency services who is potentially eligible for federal emergency services is admitted to a hospital as an inpatient at any time while the application is pending. As long as the applicant cooperates with the federal emergency services application process, the county may certify the applicant for state emergency services pending a federal emergency services eligibility determination by DES.

D. A county may conduct a telephone interview and complete a Part I Application and Part II Application, if necessary, with applicants meeting all of the following criteria:
1. The applicant on whose behalf the priority application was initiated is hospitalized out of his county of residence or is in isolation at an inpatient medical facility; and
2. There is no head of household or designated representative as defined in R9-22-306 present in the county of residence; and
3. The applicant on whose behalf the priority application was initiated was previously eligible for AHCCCS.

E. When a telephone interview is conducted, the eligibility worker shall:
1. Read the Statement of Truth to the applicant at the beginning of the telephone interview; and
2. Establish the head of household; and
3. Establish the AHCCCS family composition; and
4. Complete the Title XIX eligibility screen; and
5. Inform the head of household that collateral or documented verification is required prior to determination to verify the information received during the telephone interview and that documented verification is required within 30 days from the date of application; and
6. Inform the head of household that a face-to-face interview shall be held with the head of household or designated representative within 30 days from the date of the emergency notification or application; and
7. Inform the head of household that the Part I Application, Part II Application, Statement of Truth, Intent to Cooperate form, if applicable, and Affidavit of Citizenship or Alien Status, if applicable, shall be signed within 30 days from the date of the priority application; and
8. Record all information received in the telephone interview on the Part I Application and Part II Application including verification that two eligibility workers conducted the telephone interview; and
9. Establish mutually agreed upon follow-up arrangements in order to obtain verifications of all factors of eligibility, and to obtain the required signatures.
10. If, after 30 days, the face-to-face interview has not been completed or the Part I Application and Part II Application forms and other forms as required have not been signed, the county shall send an advance notice of discontinuance to the head of household unless it has been verified that the applicant is still incapacitated and there is no applicant identified in R9-22-306(A) or (B) who can complete the follow-up process. This situation shall be monitored by the county to insure that all eligibility requirements are fulfilled as soon as the applicant is no longer incapacitated or a representative is designated.

F. If a determination could be rendered not later than one day after the date that an applicant dies, the county shall complete the application in accordance with this Section and notify the Administration not later than one day after the applicant's date of death.

R9-22-310. Face-to-face Interview for Indigent and Medically Needy Applicants and Eligible Low-income Children

A. Except as provided in R9-22-309, all face-to-face interviews for either routine or priority applications shall be conducted by a county eligibility worker with the head of household or spouse before the eligibility worker renders an eligibility decision.

B. During a face-to-face interview for either a routine or a priority application, the county eligibility worker shall provide in applicant to the head of household, as defined in R9-22-101, the following information:
1. AHCCCS eligibility requirements.
2. EPSDT benefits available under the program.
3. Confidential nature of information received.
4. The head of household's right to appeal any adverse eligibility decision.
5. Responsibility of head of household or spouse to report any changes in circumstances which may affect eligibility within ten calendar days following the date the change occurred.
6. Responsibility of the head of household to provide truthful, accurate and complete information, and that failure to do so could result in criminal prosecution and discontinuance or denial of AHCCCS benefits.
7. The date coverage begins and enrollment process.
8. Assignment of third party liability rights to AHCCCS.
9. The requirement to provide all information and verification needed to establish eligibility within 30 days of the date of application, and that failure to provide the information within 30 days may result in denial.

10. The right to request an extension of the 30 days to establish eligibility. Each head of household who requests an extension shall be informed of the procedure and be advised that the extension may cause a delay in the eligibility decision.
11. The requirement to cooperate with the AHCCCS Administration in a review of eligibility for AHCCCS assistance.
12. The requirement to file a S.O.B.R.A. application and cooperate with the S.O.B.R.A. application process, if any of the household members are potentially S.O.B.R.A. eligible. The head of household shall be informed that the county eligibility decision for the potential S.O.B.R.A. household members may be delayed, pending an eligibility decision by DES.
13. The requirement to file a federal application and cooperate with the federal application process on behalf of any household member who is hospitalized and potentially eligible for a Title XIX eligibility category. The head of household shall be informed that the certification period for the potential Title XIX household members will be limited to the remaining days in the certification month plus two calendar months, pending an eligibility decision by DES.

R9-22-311. Head of household's Responsibility for Indigent and Medically Needy Applicants, Eligible Low-income Children, and State Emergency Services Applicants

The head of the household shall:

1. Provide complete and accurate information regarding income, termination of income, family household, property, resources, residency and medical expense information necessary for the completion of Part I Application and Part II Application forms and the determination of eligibility; and
2. Provide other necessary information and verification so that an application may be considered complete; and
3. Authorize the verification of such information as may be necessary; and
4. Notify the county eligibility office of changes in any circumstances which may affect eligibility within ten calendar days of such change; and,
5. Provide all necessary information and verification for processing an interim change within ten calendar days of the county's request for such information; and
6. Sign and date the Part I Application, Part II Application and Part II Application Addendum forms; and
7. Sign the Intent to Cooperate form; and
8. Provide the Affidavit of Citizenship or Alien Status signed by each adult household member and for each minor household member who claims to be a citizen of the United States or an alien with lawful immigration status; and
9. File claims for health care or accident insurance benefits and assign benefits and any cause of action for such resources to the AHCCCS program to the extent of the value of the medical care or treatment provided by the program; and
10. Identify and assign all health or accident insurance benefits and any cause of action against tort feasors for all household members to the extent of the value of medical care or treatment that is received by the family household.
11. Cooperate with the completion of applications for:
    a. Indigent, medically needy, or eligible low income child or state emergency services coverage;
    b. S.O.B.R.A., if there is a child or pregnant woman in the household who is potentially eligible for S.O.B.R.A.;
    c. Other Title XIX eligibility coverage when there is a hospitalized household member who is potentially eligible for Title XIX coverage; or
    d. Federal emergency services coverage if there is a household member applying for state emergency services coverage who is potentially eligible for federal emergency services coverage.

R9-22-312. Statement of Truth for Indigent and Medically Needy Applicants and Eligible Low-income Children, State Emergency Services Applicants, and Title XIX Applicants

A. The following combined Statement of Truth shall appear on applications for indigent and medically needy, eligible low-income children, state emergency services, and Title XIX status. The Statement of Truth shall be fully explained to the applicant by the county eligibility worker. The eligibility worker shall request from the applicant and receive confirmation that the Statement of Truth has been fully explained to the applicant and that the applicant fully understands the information contained therein. The Statement of Truth shall be signed by the head of household in the presence of the county eligibility worker prior to an eligibility determination:

I swear or affirm that the verbal and written statements made regarding the members of my family household, residency, citizenship or alien status, relationships, income, property, resources, and all other items that pertain to my household's possible eligibility for AHCCCS are true and correct to the best of my knowledge.

I understand that I must report within ten days changes affecting my household's income, household composition, property, resources, residence, mailing address, and any other change affecting my or our eligibility for AHCCCS benefits.

I understand that it is my responsibility to provide the Department of Economic Security, the county, and state and federal reviewers with the needed information to determine correct eligibility and benefit level. If I provide incorrect information or refuse or fail to cooperate, my benefits may be denied or stopped.

I further understand that I must cooperate in providing verification of my eligibility for AHCCCS benefits.

I understand that it is a crime punishable by law for a applicant to knowingly present false information, misrepresent, or conceal information needed to make a correct eligibility determination; obtain, or attempt to obtain, medical health coverage by falsifying identification; or give or lend identification to any applicant for the purpose of fraudulently obtaining medical care. I understand that fraud is an intentional program violation whereby I knowingly withhold or give false information with intent to receive benefits to which my household is not entitled. I understand that I will be required to pay back any benefits I received fraudulently and that I may be subject to criminal prosecution. I understand that any applicant found guilty of fraud in medical assistance programs will be subject to such fines, imprisonment, or other penalties provided for by applicable state and federal laws.

In consideration of any medical assistance received by myself or any of the dependents listed on this application, I, the undersigned, hereby assign and transfer to the Arizona Health Care Cost Containment System all rights to insurance and any other third party liability benefits accruing to me or my dependents during the period of time assistance has been granted to the extent of the actual cost of care paid under the

AHCCCS program. I will apply for any health or accident insurance benefits to which I am entitled.

I agree that, if my need of medical treatment resulted from either my negligence or someone else's negligence, and if I, my estate, or my personal representative(s) recover money or property from such negligent applicant or entity or his or her insurer, AHCCCS and the health care provider shall be entitled to liens against such recovery. I understand that a release of a claim against the negligent party is not valid unless joined in by the lien holder.

I understand that, if I disagree with any action taken on my case, I have the right to submit a written request for appeal and that I have the right to request an appeal when:

a. My application is denied in whole or in part.

b. Action on my application has not been taken by the county within 30 days and by the Department of Economic Security within 45 days of the date of my application and I have not agreed to extend the period for completing my application.

c. My AHCCCS coverage is terminated or otherwise withheld.

I authorize AHCCCS, the county of record, or the Department of Economic Security to investigate and contact any sources necessary to establish the accuracy of information which pertains to my or our AHCCCS eligibility.

I further agree to cooperate with Arizona and federal personnel in the completion of a quality control review of my eligibility for AHCCCS.

I am, and each applicant for whom I am making this application is, a resident of the county of record.

I understand that information contained in my case file is confidential and that such information may be given only to certain applicants as specified by law or regulation.

B. The following statement shall appear on the Part II Application and be signed by the county eligibility worker at the time the eligibility determination is made:

I have advised the applicant or member of his right to appeal any eligibility decision and of the obligation to report all changes affecting eligibility as well as penalties for fraud, misrepresentation and intentional omissions. I have requested and received the applicant's or member's confirmation that he fully understands these rights, obligations and penalties. I have completed my investigation of this applicant or family household for AHCCCS as required by law.

R9-22-313. Determination of Eligibility for Indigent and Medically Needy Applicants, Eligible Low-income Children, and State Emergency Services Applicants

A. The county eligibility office shall determine the eligibility status of each family household member after all the requirements listed in R9-22-309(A), (B), or (C), whichever is applicable, have been met. In determining eligibility, the worker shall complete any appropriate worksheets and other necessary forms which will itemize the computations and justify decisions made to determine household composition, citizenship or alien status, relationship, income, termination of income, net worth, liquid resources, medical expenses, 3rd-party liability information, and residency. These forms and the required documentation and verification of all pertinent facts shall be kept in the case record for a period of at least 5 years from the date of the last action and constitute a complete audit trail for quality control purposes. All AHCCCS information, forms, documentation, and verification shall be kept in a section of the case record separate and apart from any other county information contained therein. Case records shall be made available to the Administration upon request.

B. The county eligibility worker shall determine if each family household member is eligible as an indigent or medically needy applicant, eligible low-income child, or state emergency services applicant, according to pertinent statutory provisions and rules. The determination shall be made after the application has been completed by the head of household and all information has been provided and verified according to provisions of the Article. For those households with children under the age specified in A.R.S. § 36-2905.03, the county shall determine if the household's income meets the federal poverty level income guidelines when indigent or medically needy eligibility is denied or discontinued because of excess income.

C. The county eligibility worker shall complete the eligibility determination within 30 days from the date of application, or as otherwise provided by R9-22-313(F) or R9-22-309(A) or (F). The head of household shall receive a written decision notice pursuant to R9-22-316 stating whether each family household member has been determined to be an indigent or medically needy applicant, or an eligible low-income child, or eligible to receive state emergency services, or whether the family household member is ineligible for AHCCCS benefits.

1. If ineligible, the specific reason for ineligibility and reference to the rule shall be on the denial Notice of Action.
2. The Notice of Action shall be dated and mailed on the date on which the eligibility determination is made.

D. The certification period for indigent or medically needy applicants or eligible low-income children who were hospitalized at the time of application or at any time after the date of application and who are potentially eligible for Title XIX categories other than S.O.B.R.A. categories shall begin on the date of the eligibility determination and shall continue through the last day of the 2nd month after that date. Except as provided in R9-22-340 and R9-22-344, the certification period for all other indigent or medically needy applicants or eligible low-income children shall begin on the date of the eligibility determination and shall continue through the last day of the 6th month after that date, unless the county eligibility worker has verified that ineligibility may occur prior to the end of a 6-month certification period. If a applicant has been certified as an indigent or medically needy applicant or eligible low-income child for a 2-month period because the applicant is hospitalized and potentially eligible for Title XIX coverage other than S.O.B.R.A. coverage and the applicant has not refused to cooperate with the Title XIX eligibility process, and if DES has denied Title XIX eligibility for the applicant or has not completed the determination of the applicant's eligibility by the end of the 2-month certification period, the county may extend the applicant's eligibility until the last day of the 6th full month after the date of determination.

E. In no event shall the certification period of an eligible low-income child extend beyond the last day of the birthday month of the child's 14th birthday, as specified in A.R.S. § 36-2905.03.

F. During the initial 30-day period following the date of application, the county eligibility worker may extend the 30-day period for determining eligibility and receiving verification for a period of no longer than an additional 30 days only if the head of household agrees to this extension in writing.

The eligibility worker shall apprise the applicant, prior to the applicant agreeing in writing, of the consequences of such extension including a possible delay or lapse in AHCCCS coverage and the signed agreement shall indicate the applicant's knowledge of the consequences.

C. For processing an untimely application, the 30th day following either the original date of application or a previously deemed date of application shall be deemed the date of application for the purpose of calculating the household's annual income and resources. The 3-month income period shall end on the day immediately preceding the most recent deemed date of application.

H. The determination of eligibility for indigent and medically needy applicants or eligible low-income children shall be complete when the eligibility decision has been made, the decision has been communicated to the AHCCCSA Notification Unit, and the Notice of Action has been mailed to the applicant. Communication to the AHCCCSA Notification Unit and mailing of the Notice of Action shall occur on the same day.

I. Applicants who are Medicaid eligible in another state or territory shall be terminated from Medicaid prior to being auto-assigned by the county.

J. Address changes, name changes, and personal data changes shall be communicated to the AHCCCSA Notification Unit as specified in R9-22-334.

K. The period of certification for a pregnant woman who meets the requirements of R9-22-340 shall begin on the date of notification and shall continue through the last day of the 6th month after the notification, or until the last day of the month after the month of the estimated date of delivery, whichever occurs later.

L. A county shall deny an application if the household refuses or fails to provide the information and verification necessary to make an eligibility determination within time frames specified in subsections (C) and (D).

R9-22-314. Effective Date of AHCCCS Eligibility for Indigent and Medically Needy Individuals and Eligible Low-income Children

A. AHCCCS shall be responsible for payment for AHCCCS-covered emergency services rendered two days prior to the date of notification for individuals determined to be indigent, medically needy and eligible low-income children according to provisions of this Article.

B. For purposes of retroactive liability, AHCCCS is not responsible for paying the costs of emergency hospitalization and medical care which are deducted from the household's annual income to meet the income criteria for AHCCCS eligibility.

C. Full service coverage. The indigent, the medically needy and eligible low-income children shall be eligible only for emergency services commencing with the effective date of notification of eligibility; upon the effective date of enrollment with a health plan, the full scope of AHCCCS covered services shall be available to such eligible individuals.

R9-22-315. County Referrals for Applicants Potentially Eligible under Title XIX Eligibility Categories

A. County eligibility workers shall explain the Title XIX eligibility screening requirement and provide each applicant with the appropriate screening form. The information on the form shall determine whether any household member for whom assistance is requested is potentially eligible for AHCCCS eligibility under S.O.B.R.A. or other Title XIX eligibility categories. The form shall be completed by the applicant at the face-to-face interview in conjunction with the Part I for either an initial, redetermination, or interim change application.

B. Indigent, medically needy, and eligible low-income child applicants who are children or pregnant women and who are potentially eligible for S.O.B.R.A. shall apply concurrently for S.O.B.R.A. Indigent, medically needy, and eligible low-income child applicants who are hospitalized and potentially eligible for Title XIX coverage shall apply concurrently for Title XIX coverage.

C. After the county forwards an application for a household to DES, the county shall not request additional verification from the household when that verification is necessary solely for the Title XIX eligibility determination. The county may continue to receive and forward to DES any verification which was requested prior to forwarding the application or which was requested for the county eligibility determination.

R9-22-316. Notice to indigent and medically needy applicants and applicants for low-income children eligibility

A. The county eligibility office shall notify the head of household in writing of the family household's eligibility or ineligibility for AHCCCS benefits and of any changes made in their eligibility status. The notice shall be on a form prescribed by the AHCCCS Administration and shall include the name and telephone number of the eligibility worker who completed the eligibility determination, and the date the form was completed. A copy of the Notice of Action shall be placed in the case record. The Notice of Action shall be sent or given to the head of household on the date of notification and upon processing an adverse interim change.

B. The notice shall include all of the following information that applies to the action being taken for each applicant.

1. The approval and classification as either indigent, medically needy, or eligible low-income child or the denial of eligibility.
2. The denial or discontinuance, the reason an action has been taken, and the law or regulation that requires the action.
3. The advanced notice proposing discontinuance, the reason the discontinuance is being proposed, the law or rule that requires the action and the applicant's right to provide proof of eligibility to avoid discontinuance prior to the date of discontinuance.
4. The right to request a hearing and the time limits within which a hearing must be requested.
5. The procedure for requesting a hearing.
6. The expiration date of the certification period.
7. The effective date of the action.
8. The signature of the eligibility worker.

C. If the action to be taken is a discontinuance of eligibility within the certification period, the notice must be mailed to the member at least 15 days prior to the effective date of the discontinuance, unless an immediate discontinuance can be processed in accordance with R9-22-318. If the member provides proof of eligibility to the county prior to the effective date of discontinuance, an appeal is not necessary and the county shall stop the proposed action. If the member appeals the discontinuance prior to the effective date of the discontinuance, the county immediately shall attempt to resolve the eligibility dispute and shall notify the Administration within one working day following the receipt of the appeal request.

R9-22-317. Notice to contractors and nonproviders

When an applicant who has applied through the priority application process pursuant to R9-22-308 has been determined eligible or ineligible, the county eligibility office shall notify the applica-

~~ble contractor, noncontractor or nonprovider that is providing or has provided care to a household member of the determination. A written record of this notice shall be filed in the case record.~~

~~R9-22-318. Reasons for Denial or Discontinuance of Eligibility for the Indigent and Medically Needy and Eligible Low-income Children~~

~~A. The county eligibility worker shall initiate either a denial or discontinuance as specified in R9-22-801 under any of the following circumstances:~~

~~1. Countable income exceeds the limits prescribed by A.R.S. §§ 11-297, 36-2905, and 36-2905.03.~~

~~2. Countable liquid resources exceed the $5,000 limit prescribed by A.R.S. §§ 11-297, 36-2905, and 36-2905.03.~~

~~3. Countable total resources exceed the $50,000 limit prescribed by A.R.S. §§ 11-297, 36-2905, and 36-2905.03.~~

~~4. The applicant is not a resident of Arizona as defined by A.R.S. § 36-2903.01 and R9-22-301. For discontinuance of applicants, the advance notice requirement is waived if loss of state residency has been verified.~~

~~5. The applicant is not an AHCCCS household member prescribed by R9-22-307.~~

~~6. The applicant is a recipient of Title XIX in Arizona or in another state or territory. For discontinuance of a applicant, the advance notice requirement is waived if Title XIX status has been verified.~~

~~7. The applicant is an inmate of a public institution. For discontinuance of a applicant, the advance notice requirement is waived if the inmate status has been verified.~~

~~8. The applicant is an inmate of a public mental hospital. For discontinuance of a applicant, the advance notice requirement is waived.~~

~~9. Pursuant to R9-22-307(E), the applicant is a minor who is not emancipated, whose application was not filed by a qualified applicant.~~

~~10. Pursuant to R9-22-307(J), the applicant or head of household is deceased. For discontinuance of applicants, the advance notice requirement is waived if the death has been verified.~~

~~11. Pursuant to R9-22-101(5), the applicant is an AHCCCS disqualified spouse.~~

~~12. Pursuant to R9-22-101(4), the applicant is an AHCCCS disqualified spouse or an AHCCCS disqualified dependent.~~

~~13. Pursuant to R9-22-101, the applicant is a disqualified household applicant.~~

~~14. The applicant failed within the time frames specified in R9-22-313(C) and (D) or R9-22-330(A) to provide information or verification which is required to make an eligibility decision if the required information or verification has been requested in writing by the county and the head of household has been given a minimum of 10 days from the date of such written request to provide the information or verification.~~

~~15. Pursuant to R9-22-311 and R9-22-327, the applicant refused to cooperate in providing information or verification which is needed to make an eligibility decision.~~

~~16. The application forms have not been signed by the head of household or a qualified designated representative.~~

~~17. The head of household, spouse or designated representative has failed to participate in or cooperate with the face to face interview process, pursuant to R9-22-310(A).~~

~~18. The head of household, designated representative or other applicant acting on behalf of the AHCCCS family household requests a withdrawal. For recipients, if the withdrawal is made in writing, the advance notice requirement is waived.~~

~~19. The applicant's whereabouts are unknown.~~

~~20. The household has failed or refused to cooperate with the Administration's eligibility quality control review or analysis.~~

~~21. Pursuant to R9-22-311, the household refused to assign health or accident benefits to the Administration.~~

~~22. Effective with applications initiated after June 30, 1993, pursuant to R9-22-302, the applicant is not either a citizen of the United States or an alien who meets the requirements of 42 CFR 435.406(a), March 14, 1991, incorporated by reference and on file with the Office of the Secretary of State.~~

~~23. Effective July 1, 1996, applicants who are ineligible for coverage pursuant to R9-22-344.~~

~~B. Notification of discontinuance to the Administration.~~

~~1. The county eligibility office shall communicate all eligibility discontinuances to the AHCCCSA Notification Unit.~~

~~2. If the advance notice of discontinuance is waived, the discontinuance shall be communicated to the Administration on the date the Notice of Action is mailed.~~

~~3. If the advance notice of discontinuance is not waived, the discontinuance shall be communicated to the Administration on the 16th day after the date of the Notice of Action. The 16th day shall be computed as specified in R9-22-801(C).~~

~~C. Effective date of discontinuance.~~

~~1. Discontinuance due to death shall be effective on the date of death.~~

~~2. When a applicant has voluntarily requested discontinuance, the discontinuance shall be effective 2 days following the date on which the discontinuance is communicated to the Administration.~~

~~3. Discontinuance due to the applicant being an inmate in a public institution or in a public mental hospital shall be effective on the date on which the discontinuance is communicated to the Administration.~~

~~4. Discontinuance for reasons other than those delineated in paragraphs (1) through (3) shall be effective the last day of the month during which the discontinuance is communicated to the Administration, except if the discontinuance is communicated to the Administration on either of the last 2 days of the month, it shall be effective on the last day of the next month.~~

~~R9-22-319. Action After Eligibility Denial or Discontinuance~~

~~A. A head of household whose eligibility is denied or a applicant whose services are discontinued for any reason may:~~

~~1. Reapply at any time.~~

~~2. Appeal the action by requesting a hearing.~~

~~B. If a discontinuance resulted from failure to cooperate with the AHCCCS Administration's quality control review or analysis, the county shall give written notice to AHCCCS quality control if a reapplication occurs within ten months of the discontinuance.~~

~~R9-22-320. Repealed~~

~~R9-22-321. Income for the Indigent and Medically Needy and Eligible Low-income Children~~

~~A. The following items shall be considered earned income for the purposes of determining eligibility.~~

1. Gross earnings from employment including vacation and sick pay.
2. Gross earnings from self-employment.
3. Tips.
4. Commissions and other bonuses.
5. Day Care or babysitting payments received from a private individual or organization.
6. Gross proceeds received as rent for real property.
7. Payment received for room or board or both.
8. Student Work-Study income.
9. Gross earnings from federal work and job training programs.
10. Any other earned income received by the applicant or family household member which is not specifically disregarded in subsection (C).

B. The following types of income shall be considered unearned income for the purpose of determining eligibility.
1. Strike pay.
2. Arizona Training Program.
3. Retirement funds, pensions and annuities.
4. Child support.
5. Court ordered spousal maintenance or alimony.
6. Allowances and stipends received from federal work and job training programs.
7. Vocational Rehabilitation incentive payments.
8. Cash public assistance payments.
9. Indian reservation incomes including Bureau of Indian Affairs — General Assistance, Tribal Work Experience Program (TWEP) and Tribal Assistance Programs and Projects (TAPP).
10. Railroad retirement benefits.
11. Industrial Commission benefits.
12. Unemployment Insurance benefits.
13. Veterans Administration benefits.
14. Social Security Administration benefits.
15. Workman's Compensation.
16. Except as provided in R9-22-321(C), all income from legal settlements and judgments.
17. Insurance payments or awards.
18. Trade readjustment assistance under the Trade Readjustment Act except as provided in R9-22-321(C)(11).
19. Both principal and interest from the sale of real or personal property when ownership of the property has not been transferred to the buyer.
20. Cash contributions except as provided in R9-22-321(C)(22) and (23).
21. Title IX Senior Community Service Employment Program (SCSEP).
22. Foster Care Payments.
23. Adoption subsidy payments.
24. Loans that are not evidenced by a dated, written repayment agreement which was signed by the party to be charged with repayment at the time of or prior to the financial exchange.
25. Interest.
26. Lump sum payments.
27. Other unearned income not disregarded in subsection (C).

C. The following items shall be disregarded and shall not be considered income for purposes of determining eligibility.
1. Relief granted pursuant to A.R.S. § 43-1072, earned credit for property taxes for residents 65 years of age or older.
2. All income in kind.
3. All public relocation assistance payments.
4. Indian Claims Commission or Court of Claims judgment funds (also known as per capita payments to Indian tribes), including interest on these funds while still in trust, regardless of the tribe or the Public Law number.
5. Those Alaska Native Claims Settlement Act benefits which are tax exempt.
6. Income earned by a child until the child's 16th birthday when the child is not emancipated or expressly emancipated.
7. Compensation provided to volunteers over age 60 in the Retired Senior Volunteer Program, the Foster Grandparent Program, and the Older American Community Service Program.
8. Loans, grants, scholarships and fellowships insured by the federal Commissioner of Education and benefits received under the Veterans Education Assistance Program for educational purposes.
9. Death benefits exclusively used for funeral or burial expenses or both.
10. Educational, commuting, relocation, and job search allowances provided under the Trade Readjustment Act.
11. Income of a nonAHCCCS household member.
12. Emergency and Energy Assistance Payments.
13. Lump Sums received as conversion of assets.
14. Loans, provided there was a dated written repayment agreement at the time of the financial exchange, which was signed by the party to be charged.
15. If excessive income is due to the inclusion of earned or unearned income received during the 13-week income period due solely to a shorter calendar month (February), then monies received from the earliest pay date that would not otherwise be received in the 13-week income period may be excluded.
16. Payments made directly to a third party by friends, relatives, charities or agencies on behalf of the applicant or household.
17. Cash exchanged between indigent, medically needy, eligible low income children, and state emergency services household members.
18. Cash exchanged between indigent, medically needy, eligible low income children, or state emergency services family household members and categorically eligible household members who would have been included as part of the AHCCCS family household except for their categorical status.
19. Condemnation awards for the condemnation of the principal place of residence.
20. Reimbursement for medical care from a third party liability source.
21. Money that an applicant or the applicant's household receives as a result of a settlement agreement or a judgment in a lawsuit brought against a manufacturer or distributor of Agent Orange.
22. Reparation and restitution payments pursuant to Section 1902(r) of the Social Security Act, November 5, 1990, incorporated by reference herein and on file with the Office of the Secretary of State.
23. Reimbursement for training related expenses, subsistence and maintenance allowances, on the job training wages or other wages related to vocational rehabilitation and paid to applicants engaged in a veteran-, federal-, or state sponsored vocational rehabilitation program.
24. Compensation paid to volunteers in the VISTA program.

D. The following expenses shall be deducted from income for the purposes of determining eligibility:

1. Payment of court-ordered spousal maintenance, alimony, or child support by the applicant or family household member provided the expense was paid by an AHCCCS household member during the three-month income period.
2. Unreimbursed employee work-related expenses, including: expenses incurred solely because they are, required by the employer; union or association dues; and employment agency fees. The expense shall have been paid by an AHCCCS household member during the three-month income period.
3. Cost of child care or disabled dependent care related to employment or job search or both provided the expense was paid by an AHCCCS household member during the three-month income period.
4. Medical expenses incurred by family household members during the 12 months prior to the date of determination for eligibility for which the family household is financially liable, and which are not subject to any applicable third party payment, shall be deductible from annual net income in order for the family household to meet the income eligibility criteria. Costs incurred for medically necessary services for daily living are included as medical expenses only if the service is rendered by someone other than the spouse of the recipient of the services or, if the recipient is a minor child, a parent of the recipient. In cases where the family household is incurring medical expenses and can be reasonably expected to reach the allowable income limit within 30 days from date of application, the date the income eligibility criteria is met shall be the date from which to calculate the 12-month period. In cases where the family household is incurring medical expenses and can be reasonably expected to reach the allowable income limit within 30 days from date of application, the application shall not be denied until the 30th day from date of application unless otherwise determined ineligible.
5. Educational expenses which are deductible from educational income are tuition, books, lab fees, other mandatory student fees provided the expense was paid during the 13-week income period.
6. Overhead expenses of producing self-employment income provided the expenses were incurred during the 13-week income period. Self employment expenses shall not be deducted from income other than self-employment income.
7. That amount which has been deducted from unearned income specified in R9-22-321(B) for the purpose of repaying an overpayment.
8. Legal or attorney fees which are withheld from Industrial Commission benefits and which are deductible from gross Industrial Commission benefits.

E. Income paid to a applicant at the direction of, or with the consent of, the beneficiary who is entitled to that income, shall be considered income of the entitled beneficiary.

F. All information pertaining to the calculation of annual income and to the termination of income for family household members shall be established and verified prior to the eligibility determination according to the requirements and time frames specified in R9-22-327.

R9-22-322. Determining Annual Income for the Indigent, the Medically Needy, and Eligible Low-income Children

A. Annual income shall be calculated by subtracting overhead expenses of producing income incurred and allowable deductions paid during the three months immediately prior to the date of application, redetermination, interim change, or the deemed date of application, from the countable income received by the family household members during those three months and then multiplying the result by four.

B. Income is considered to be received when it becomes available, except for income which is received in periodic intervals of three months or more or income which is received in a lump sum at the option of the recipient or of the payor. Such aggregate payments shall be prorated weekly over the interval between payments or over the time period which the payment is specified to cover rather than counting the aggregate amount as of the date received. One-time only payments which are not designated to cover a specific time period shall be prorated over 52 weeks. The prorated weekly amount shall be deemed as received during each week of the specified period.

C. For the purpose of calculating income, three months shall be considered equivalent to 91 days (13 weeks). If any family household member receives regular monthly or bimonthly income, and that monthly or bimonthly income was only received two times, or for bimonthly five times, during the 91-day period, but a third check, or for bimonthly a sixth check, was received on the day immediately preceding the first day of the 91-day period, then for the purpose of calculating income for that household, three months' payments shall be considered equivalent to 92 days (13 weeks and one day).

D. The terms "13-week period" and "13-week income period" used elsewhere in this Article are defined as the three months set forth in R9-22-322(C), immediately preceding the application date.

R9-22-323. Resources for the Indigent, the Medically Needy, and Eligible Low-income Children

A. Equity in the resources identified in subsections (B) and (C) of this Section, owned by an AHCCCS family household member, shall be counted in determining if resources of the family household are within the allowable eligibility limits. The resources of all household members as defined in R9-22-307 shall be included in calculating resources for determining low-income children eligibility.

B. The following resources shall be considered liquid:
1. Cash on hand.
2. Accounts in financial institutions.
3. Stocks and bonds.
4. Available trust accounts.
5. Cash surrender value of life insurance policies or prepaid burial policies.
6. Savings certificates including certificates of deposit and treasury bills.
7. Condemnation awards in excess of the assessed value of real property subject to the condemnation, if the excess remains available.
8. Interest accrued.
9. Negotiable promissory notes.
10. Other liquid resources not excluded in subsection (D) of this Section.

C. The following resources shall be considered nonliquid:
1. Business properties.
2. House or homestead.
3. Land or real property.

4. Mobile home.
5. Rental property.
6. Trucks.
7. Automobiles.
8. Boats and trailers.
9. Motorcycles and all terrain vehicles.
10. Vans.
11. Other motor or recreational vehicles.
12. Livestock and grazing permits.
13. The principal balance due on written sales contracts or mortgages when ownership of the resource is no longer with the seller.
14. Mining claims.
15. Mineral rights.
16. Inheritances.
17. Jewelry other than wedding and engagement rings.
18. Inventory, tools, and machinery in excess of $500 not used for business, provided the applicant does not plan to use the tools for business within the next six months.
19. Condemnation awards for the condemnation of the principal place of residence up to the assessed value of the property for 12 months from the date of receipt or until the date of purchase of a new principal place of residence, whichever occur sooner.
20. Other nonliquid resources not excluded in subsection (D) of this Section.

D. The following resources shall be excluded:
1. Household furnishings.
2. Personal items, clothing.
3. Household pets.
4. Resources owned by individuals who are not part of the AHCCCS family household as defined in R9-22-307.
5. Property that is not available because it is the subject of litigation.
6. The unexpended portion of educational grants, loans, scholarships, and fellowships left on account in a financial institution during the period of time for which the funds were intended.
7. Public relocation assistance monies.
8. Separate property of an AHCCCS disqualified spouse, the equity in which does not exceed $75,000. Equity in excess of $75,000 shall be counted, unless otherwise provided by law.
9. Inventory, tools, and machinery used for business.
10. Money that an applicant or the applicant's household receives as a result of a settlement agreement or a judgment in a lawsuit brought against a manufacturer or distributor of Agent Orange if identifiable and held separately.
11. Funds from reparation and restitution payments pursuant to Section 1902(r) of the Social Security Act, November 5, 1990, incorporated by reference herein and on file with the Office of the Secretary of State.

E. The ownership and value of all property and resources for family household members shall be established and verified prior to an eligibility determination according to the requirements and time frames specified in R9-22-327.

R9-22-324. Evaluating Resources

A. The county eligibility worker shall consider the value of resources owned by the applicant or family household as of the date of application, redetermination, interim change or the deemed date of application.
1. Calculate the total value of the liquid assets.
2. Determine the total equity in the remaining property and resources.
3. Calculate the net worth by adding the value of the total liquid assets to the total equity in the nonliquid assets.

B. Separate property of an AHCCCS disqualified spouse shall be valued at the county assessor's full cash value.

R9-22-325. Ownership of Resources

A. The owner of nonliquid resources is the applicant who holds legal title to or provides other evidence of ownership of the resource. If the nonliquid resource is owned by more than one individual, it shall be presumed that the resource is owned by all owners in equal shares unless the applicant demonstrates by clear and convincing evidence that a different allocation should be used based upon each owner's proportionate contribution.

B. The owner of liquid resources is the applicant who holds legal title to or provides other evidence of ownership of the resource. If the liquid resource is owned by more than one individual, it shall be presumed that the resource is fully available to the applicant unless the applicant demonstrates by clear and convincing evidence that all or part of the resource is unavailable, that the applicant has neither contributed to nor benefited from it, and the applicant changes the account designation, removing the applicant's name from the account or separating the part for which ownership is claimed from the remainder and removing the applicant's name from the remainder.

R9-22-326. Transfer of resources for the indigent, the medically needy, and eligible low-income children

A. Transfer of property or resources by a family household member within three years prior to the date of application shall not result in ineligibility for indigent, medically needy, or eligible low-income child coverage if any one of the following conditions was met:
1. Fair consideration was received. To receive fair consideration at least 80% of the assessors' full cash value for real property and at least 80% of the market value for personal property shall have been received.
2. The equity of the property or resource at the time of transfer, when added to the value of other resources owned at the time of transfer would not have resulted in ineligibility.
3. Foreclosure or repossession of the property or resource was imminent at the time of transfer, and there is no evidence of collusion.
4. The transfer was made without fair consideration, and the value or equity would have resulted in ineligibility, but the individual establishes by clear and convincing evidence that the transfer was not made for the purpose of establishing eligibility.

B. There is a presumption that property transferred by the individual more than three years preceding the date of application was not transferred to establish eligibility. Such property or resource shall not be considered in determining eligibility.

C. The transfer of property or resources by an individual shall result in AHCCCS ineligibility if the transfer did not meet at least one of the conditions specified in subsections (A) or (B) of this Section.

R9-22-327. Verification of Information for the Indigent, the Medically Needy, and Eligible Low-income Children

A. Information necessary to complete the AHCCCS application shall be verified. Verification shall be defined as documented, collateral or member's declaration.
1. Documented verification is evidence in written form provided on an official document from a applicant qualified to have knowledge of the information provided.

Documented verification may be secured from the applicant or from a third party. The document shall include the date, the source, and the content. Information establishing the qualifications of the verification source shall be in the case record. The document or a copy of the document shall be filed in the case record. Unless otherwise specified in this Article, attempts to obtain documented verification shall be made prior to accepting collateral verification.

2. Collateral verification is evidence in verbal form from a specified applicant qualified to have knowledge of the information provided. Unless otherwise specified in this Article, attempts to obtain documented and collateral verification shall be made prior to accepting a member's declaration. When collateral verification is used, the case recordings shall include the following:
   a. The date of the contact; and,
   b. The type of contact; and,
   c. The name, title, phone number and address of the applicant providing the evidence; and,
   d. The name and title of the applicant receiving the information; and
   e. A statement explaining how the applicant is qualified to provide the information; and,
   f. Information that was provided.
3. Member's Declaration is information in written form signed by the member including the member's declaration of information and the date the declaration was written. The individual's declaration shall not serve as acceptable verification unless an exception is provided for in this Article. When the member's declaration is used, the case record must contain the following:
   a. Attempts made by the eligibility worker to obtain documented and collateral verification; and,
   b. Reason why the individual's declaration is being accepted; and,
   c. What the declaration says as it relates to the factor of eligibility.
4. When documented verification is not immediately available, collateral evidence may be accepted for either priority or routine applications.

B. Information, verified according to the requirements of this Section, not subject to change, and contained in existing case records shall be considered in determining or redetermining eligibility for AHCCCS. When used, the current case record shall refer to the verification information contained in previous case records.

C. Responsibility for obtaining verification.
1. The head of household shall:
   a. Sign all release of information forms requested by the county relating to income, resources, residency, and relationship.
   b. Supply the documented verification or the names, addresses, and phone numbers of applicants for collateral verification within ten days of the request from the county or AHCCCS quality control or within a time frame which is mutually agreed upon in writing by the head of household and the eligibility worker, or AHCCCS quality control.
   c. Supply the declaration only after the eligibility worker has determined that documented or collateral verification does not exist or is unavailable. The applicant or member shall then provide the written declaration of the facts and attest to the truth of his statement.
   d. Cooperate so that an accurate eligibility determination can be reached. If the applicant or member fails or refuses to cooperate the eligibility shall be denied or discontinued.
2. The county shall:
   a. Inform the head of household in writing at the face to face interview what verification or information is needed and allow the client ten days to supply the verification requested.
   b. Make suggestions to the head of household regarding how to obtain the required verification;
   c. File all verification documents in the case record.
   d. Record verification information in the case record.
   e. Insure the case record contains proof and explanations of all eligibility decisions and actions.
3. If the head of household does not have or cannot obtain or if he or she would like help in obtaining the verification requested, the head of household shall sign a release of information form to allow the county eligibility worker to obtain verification. If the head of household signs a release of information, the eligibility worker shall mail the request for information within two working days from the date the head of household signs the release of information.

D. Verification of annual income.
1. All information pertaining to the calculation of annual income and to termination of income shall be verified prior to a determination for all initial, redetermination, and priority applications, and when there is an interim change in income.
2. Verification of income received shall establish:
   a. The date the income was received; and
   b. The applicant who received the income; and
   c. The gross amount of the income; and
   d. The source of the income; and
   e. The qualifications of the verification source.
3. Verification of income deductions.
   a. Verification for self employment work expenses as specified in R9-22-321(D)(6) shall establish, other than by a member's declaration:
      i. The date the expense was incurred; and
      ii. The amount incurred; and
      iii. The type of expense; and
      iv. The identity of the applicant responsible for payment.
   b. Deductions from income as specified in R9-22-321(D)(1), (2), (3) shall establish:
      i. The date the expense was paid; and
      ii. The amount paid; and
      iii. The type of expense; and
      iv. The identity of the applicant who paid the expense.
   c. Medical expense deductions as specified in R9-22-321(D)(4) shall establish:
      i. The type of medical expense; and
      ii. The date the expense was incurred; and
      iii. The amount of member liability not subject to third party liability or otherwise written off by the provider prior to the date of determination; and
      iv. The identity of the applicant who incurred the expense; and
      v. The qualifications of the verification source.
   d. Verification of disregarded income shall establish:
      i. The type of income; and

ii. The date the income was received; and
iii. The identity of the applicant receiving the income; and
iv. The source of the income; and
v. The qualifications of the verification source.

4. Annual income verification process.
a. Except for self-employment income and as provided in (A)(4) of this Section, documented verification shall be attempted as a first priority.
b. If documented verification cannot be obtained then collateral verification with the employer or source providing income shall be obtained as the second priority in accordance with R9-22-327(A)(2), (4), (5). All collateral verifications and collateral attempts shall be recorded in the case record.
c. The signed member declaration may be utilized as the third priority only when the third party has refused to provide the information requested. This shall only be utilized when all sources for receiving documented or collateral verification have been exhausted and recorded in the case record.
d. For verification of self-employment income, the member may serve as the primary verification source. The applicant must provide the information required under subsection (D)(2) of this Section.

E. Verification of resources.
1. Except as provided in subsection (B) and (A)(4) of this Section, all information pertaining to the calculation of resources shall be verified in the following manner prior to a determination for initial, redetermination, priority applications, and when there is an interim change in resources. All resource verification attempts shall be recorded in the case record.
2. Resource verification shall establish:
a. The type of resource; and,
b. The owner of the resource; and,
c. The encumbrance, if needed, to bring the household's resources within the limit; and,
d. The assessor's full cash value of real property and the market value of applicantal property at the time of application of transfer.
e. The qualifications of the verification source.
3. Except as provided in (A)(4) of this Section, documented verification for resources of all family household applicants, with the exception of cash on hand, jewelry, and tools and machinery used for business, shall be attempted as a first priority. Once the ownership and value of real property has been verified, it is not necessary to reverify at every determination unless the household is within $5,000 of the total property limit of $50,000.00. The value shall be verified each calendar year.
4. If documented verification cannot be obtained and the attempt is recorded in the case record then collateral verification with an official source shall be obtained as a second priority in accordance with R9-22-327(A)(2), (4), and (5). All collateral verifications and collateral attempts shall be recorded in the case record.
5. The signed member declaration shall be utilized as the third priority only when the third party has refused to provide the information requested. This shall only be utilized when all sources for receiving documented or collateral verification have been exhausted and attempts have been recorded in the case record.
6. The head of household's declaration of value for cash on hand, jewelry, and tools and machinery used for business, shall be acceptable verification unless there is reason to believe an appraisal of the item(s) might result in ineligibility.
7. Verification of transferred property.
a. The applicant shall provide verification of real property transferred within three years prior to application. The applicant shall provide a member's declaration of all applicantal property transferred within the three years prior to application.
b. The applicant shall provide a member's declaration of the type, value and equity of all applicantal property owned at the time of transfer.
c. When the county has reason to believe applicantal property may have been transferred for the purpose of establishing eligibility, verification in accordance with subsections (A), and (E)(4), (5), (6) and (7) of this Section shall be required. The eligibility status shall then be evaluated in accordance with R9-22-326 of these rules.

F. All Arizona residency information shall be verified pursuant to R9-22-301.

G. Verification of relationship and household composition.
1. Except as provided in subsection (B) and (A)(4), all information regarding household composition, emancipation, categorical status and relationship of family household members, including specific relatives, shall be verified prior to a determination for an initial, priority, or redetermination application and when new members are added to the family household, through documented verification. Household composition shall be verified each time the AHCCCS family household has a change of address. Documented verification already contained in the case record shall be utilized in a redetermination application, if no change occurs.
a. Verification for relationship shall include:
i. The names of the individuals whose relationship it is intended to verify.
ii. The relationship of the individuals.
iii. The source of the verification.
iv. The qualifications of the source of verification.
b. If documented verification for relationship, categorical status, and emancipation cannot be obtained and the attempt is recorded in the case record, then collateral verification shall be obtained as the second priority in accordance with R9-22-327(A)(2), (4), and (5). All collateral verification and collateral attempts shall be recorded in the case record.
c. The signed member's declaration shall be utilized as the third priority only when attempts to obtain documented or collateral verification have been exhausted and recorded in the case record.

H. Verification of third party liability. Except as provided in subsections (B) and (A)(4) of this Section, all information regarding third party liability shall be verified prior to a determination for an initial or redetermination application, or when a new individual is added to the family household. Third party resources shall be substantiated by documented verification such as health insurance card, Medicare claim card, Medicare notice, or any other Social Security notice or claim form which substantiates Medicare entitlement, or through collateral verification with the agent or agency pro-

viding third party coverage. Except as otherwise provided in R9-22-707, the Administration shall be notified, at the time of notification, of the health insurance claim number, indication of Medicare Parts A and/or B entitlement, and the effective dates of Parts A and/or B entitlement.

I. Verification of age shall be obtained prior to initial determinations, redeterminations, and priority applications for an eligible low-income child or a state emergency services applicant who would otherwise be eligible as an eligible low-income child.

J. Verification of citizenship or alienage.

1. Each adult applicant who claims to be a United States citizen or an alien with lawful immigrant status shall sign an affidavit under penalty of perjury that the applicant is a citizen of the United States or a lawful resident alien. For minors, the affidavit shall be signed by a parent, specified relative, or legal guardian.
2. In addition to signing the affidavit, when a applicant who alleges United States citizenship is born outside the United States or its outlying possessions, documented verification of United States citizenship shall be obtained prior to approval for coverage as an indigent or medically needy applicant or as an eligible low-income child.
3. In addition to signing the affidavit, no applicant who claims to be an alien with lawful immigration status shall be approved for coverage as an indigent or medically needy applicant or as an eligible low-income child until verification of alien status has been obtained.

R9-22-328. Redeterminations for the indigent, the medically needy, and eligible low-income children

A. A member classified as indigent, medically needy or an eligible low-income child shall have his or her eligibility redetermined by the eligibility office in the member's county of residence at least once every six months except as provided in subsection (E) of this Section or R9-22-340 of these rules. The six-month period shall be calculated from the first day of the month following the date of notification.

B. In order to avoid a break in AHCCCS coverage, a redetermination must be completed and notification made to the Administration pursuant to R9-22-334, no later than three days prior to the last day of the month of the member's expiration date.

C. A redetermination may be requested by a member or county eligibility office when there is reasonable cause to believe there has been a change in circumstances affecting eligibility.

D. The county eligibility office shall complete a redetermination according to the same procedures followed in the initial determination of eligibility and verify additional information or information contained in the case record which is subject to change according to verification requirements of this Article. The county eligibility workers shall evaluate existing case record information. The evaluation shall compare current application information with existing case information to identify inconsistencies and to determine their effect upon continued eligibility. The case record shall demonstrate this evaluation.

R9-22-329. Date of AHCCCS coverage for categorically eligible applicants and eligible assistance children

A. AHCCCS shall be responsible for the payment of all covered services provided to categorically needy individuals from the first day of the month of application, except as otherwise provided in R9-22-334 and with the exception of SSI recipients who become Arizona residents while receiving SSI benefits. The date of AHCCCS coverage under these circumstances is as specified by the Social Security Administration. Retroactive coverage shall be provided in accordance with R9-22-304.

B. AHCCCS shall be responsible for the payment of all covered services provided to eligible assistance children from the date on which notification of eligibility from the Arizona Department of Economic Security is received by the AHCCCS Administration.

R9-22-330. Reporting interim changes for the indigent, the medically needy, and eligible low-income children

A. Time frames for reporting interim changes for the indigent, the medically needy and eligible low-income children. The head of household or spouse shall report changes in income, family household, property, resources, residence, and any other change which may affect eligibility to the county eligibility worker within ten calendar days that the change occurs. A change report also may be initiated by other family members or by nonfamily members. When the county eligibility office receives a report of a change in income, family household, property, resources, residences, and other changes, the county eligibility worker shall evaluate the effect on eligibility for continued benefits within two working days from the date the information became known to the county eligibility worker. The county shall evaluate the household's continued eligibility. If ongoing eligibility is indicated, the member shall be allowed ten days from the date of written notification to supply the verification and information requested. The county shall send a Notice of Action proposing discontinuance if the verification is not received within this ten day period. If ineligibility is indicated by the change, the county shall send a Notice of Action proposing discontinuance based on the information available to the county. Changes reported prior to notification shall be evaluated in accordance with R9-22-331.

B. County to county relocations for the indigent, the medically needy and eligible low-income children.

1. If the member reports an address change to the initial county eligibility office, the county eligibility worker shall provide the member with a copy of the Part I Application in the case record for the current period of eligibility and the address of the eligibility office in the county to which the member is relocating.
2. When an AHCCCS member presents a Part I Application from the previous county of residence as specified in paragraph (1) of this subsection, the eligibility worker shall verbally verify with the member that the information on the Part I Application is correct. If the Part I Application is not provided by the member, the eligibility worker shall contact the previous county and request that the information for the completion of the Part I Application be provided by phone. A new Part I Application with an updated member address shall be completed by the eligibility worker and the notification phone call placed as specified in R9-22-334. The previous county of residence shall send a copy of the member's AHCCCS case file to the new county of residence within five working days of the notification. A written release of information shall not be required.

C. Within county relocations for the indigent and the medically needy.

1. When an AHCCCS head of household or applicant authorized to act on behalf of the eligible low-income children reports an address change which includes a change of zip code within the household's current

county of residence, the eligibility worker shall review the Part I Application on file with the head of household or applicant authorized to act on behalf of the eligible low-income children and complete a new, updated Part I Application. Once completed, the eligibility worker shall place the auto-assignment phone call as specified in R9-22-334.

2. When an AHCCCS member reports an address change within the member's current county of residence that does not include a change of zip code, the county eligibility worker shall notify AHCCCS of the change in address through the auto-assignment telephone call as specified in R9-22-334.

D. Notification requirements for contractor changes for the indigent, the medically needy and eligible low-income children. Upon receipt of notification that a member has permanently changed his address out of his present contractor's service area, the Administration shall disenroll the member from his present contractor and shall enroll the member with an appropriate contractor.

1. If notification to the Administration is from a source other than the county, the Administration shall notify the appropriate counties.
2. If a contractor notifies the Administration that a member has permanently moved out of its service area, the contractor shall provide a preponderance of credible evidence supporting the member's move.

E. Relocations for eligible low-income children. The head of household or applicant authorized to act on behalf of the eligible low-income child(ren) shall present himself at the AHCCCS enrollment site with a copy of his Part I Application.

1. If the member's current contractor is available in the new residential zip code area, the member must be enrolled with the same contractor.
2. If the member's current contractor is not available in the new residential zip code area, the member shall choose a new contractor for his residential zip code area within a time period prescribed by the Director.

R9-22-331. Re-evaluation of the Indigent, the Medically Needy, and Eligible Low-income Children

A re-evaluation of eligibility for a applicant classified as indigent, medically needy or eligible low-income child shall be required when a change in any factor which may affect eligibility becomes known to the county. When performing a re-evaluation of interim changes, the eligibility requirements that changed shall be verified in accordance with this Article and any verification requirement not previously satisfied shall be satisfied prior to adding an eligible applicant. The newly verified information, when applied to the existing information in the case record, shall be compared to eligibility requirements to determine if eligibility should continue. If a re-evaluation results in the household exceeding the income limits, a redetermination shall be performed.

R9-22-332. Eligibility Offices; Hours and Location

A. County eligibility offices shall file with the Director, on July first of each year, the locations and hours of operations of all eligibility offices at which a applicant may submit an application for AHCCCS eligibility. Changes in the locations and hours of operation of eligibility offices shall be reported to the Director ten days prior to the proposed effective date of such a change.

B. AHCCCS shall notify the county eligibility offices annually of the hours of operation for the receipt of notification telephone calls. Changes in the hours of operation during which notification telephone calls will be accepted shall be sent to the county eligibility offices in writing five work days prior to the proposed effective date of such a change.

R9-22-333. Enrollment of Eligible Applicants with AHCCCS Contractors

A. The Administration shall enroll AHCCCS categorically eligible applicants, eligible assistance children and eligible low-income children with an AHCCCS contractor which serves the applicant's geographic area.

B. A applicant certified as categorically eligible, an eligible assistance child or an eligible low-income child for AHCCCS benefits, but residing in an area not served by an AHCCCS contractor, shall be provided the full scope of AHCCCS services under the terms and conditions as specified in Article 7 of these rules.

C. Categorically eligible applicants, eligible assistance children and eligible low-income children residing in an area served by more than one AHCCCS contractor shall have freedom of choice in the selection of an AHCCCS contractor. Categorically eligible applicants, eligible assistance children and eligible low-income children shall select a contractor authorized to provide AHCCCS benefits within the applicant's geographic area. Such choice may be limited when only one contractor is available to an eligible applicant in a given geographic area. Categorically eligible applicants, eligible assistance children and eligible low-income children failing to make a choice when such choice is available shall be enrolled by the Administration by assignment.

D. AHCCCS shall enroll indigent and medically needy individuals with an AHCCCS contractor through the auto-assignment process pursuant to R9-22-334.

E. The Administration may approve the transfer of enrolled members from one contractor to another under conditions specified in Article 5 of these rules and as otherwise determined necessary by the Director.

F. Emergency services programs.

1. Applicants approved on or after July 1, 1993, for state emergency services or federal emergency services shall not be enrolled with a contractor.
2. Providers of emergency services for applicants approved for state emergency services or federal emergency services shall be reimbursed by the Administration on a fee-for-service basis under the terms and conditions specified in Article 7 or on a specialty contract basis pursuant to R9-22-716.

R9-22-334. Communication of Eligibility for the Indigent, the Medically Needy, and Eligible Low-income Children

A. The Administration shall process eligibility determinations communicated from the county eligibility office, with the exception of denials.

B. The County eligibility office shall communicate all eligibility determinations, with the exception of denials, to the AHCCCSA Notification Unit. The county eligibility office shall provide all of the following information for each eligible applicant:

1. Identification number of the eligibility worker and of the eligibility site.
2. Case identification number, if available.
3. AHCCCS recipient identification number, if available.
4. Type of action.
5. Applicantal and demographic information about the eligible applicant.
6. Other information which the Administration has requested in writing.

C. Communication to the AHCCCSA Notification Unit shall be by telephone or by other means approved by the Administration.

R9-22-335. Notice to contractors and effective date of enrollment for individuals eligible for AHCCCS

A. The Administration shall provide verbal or written notice to a contractor for each applicant to be enrolled in the contractor's plan. Notice shall include the name of the newly enrolled member, and AHCCCS member identification number, and the effective date of a contractor's liability.

B. If a member becomes ineligible and is subsequently determined eligible, the applicant shall be re-enrolled with the contractor of record except under the following circumstances:

1. A member moves out of the service area of the current AHCCCS contract health plan and the current contract health plan has no contract for the new service area of the member's residence.
2. A member chooses another contractor during an open enrollment period.
3. A plan's contract is suspended or terminated.
4. The Administration approves a change of contractor as a result of a grievance resolved through the grievance process.
5. A member has been disenrolled from this health plan for more than 90 consecutive days.

C. Categorically eligible applicants who voluntarily requested termination of their AHCCCS eligibility and who subsequently request reinstatement shall be re-enrolled under the provisions of subsection (B) of this Section.

R9-22-336. Deferred liability

A. Deferred liability. The Director may defer financial liability in whole or in part for AHCCCS members on the effective date of enrollment, if one of the following conditions or situations exists.

1. The member is a sick newborn on the date of enrollment.
2. The member is hospitalized on the date of enrollment.
3. Other circumstances set forth in the prepaid capitated contract.

B. Deferred liability may be extended beyond the initial authorized period to facilitate continuity of care when authorized by the Director as provided in Article 7 of these rules.

C. The contractor shall submit deferred liability claims to the Administration as prescribed by R9-22-703.

R9-22-337. Guaranteed enrollment for categorically eligible applicants and eligible assistance children

A. Except as prescribed in subsections (B) and (C), at the time of a applicant's initial enrollment as an eligible assistance child or a categorically eligible applicant, he or she shall retain AHCCCS enrollment for a period not less than five months even if the applicant becomes otherwise ineligible before the end of that period. This guaranteed enrollment applies only once per member for categorically eligible applicants and only once per member for eligible assistance children. A applicant may receive separate guaranteed enrollment periods as a categorically eligible applicant and as an eligible assistance child. The guaranteed enrollment period shall begin on the effective date of enrollment and shall continue for five calendar months from the first day of the month following the effective date of enrollment.

B. Enrollment shall be terminated:

1. Retroactively for members whose eligibility expires due to death.
2. No later than 60 days after the date when the Administration is notified that a member has moved out of state.
3. Immediately upon written notification of a voluntary withdrawal from AHCCCS benefits.

C. Enrollment of an eligible assistance child shall be terminated:

1. At the end of the birthday month of the year specified in A.R.S. § 36-2905.03.
2. Upon notification of termination of eligibility for failure or refusal to cooperate with the S.O.B.R.A. eligibility process.

R9-22-338. Verification review by the Director for the indigent, the medically needy, and low-income children

At the discretion of the Director, the AHCCCS Administration shall review any county's completed priority or routine applications, prior to notification of eligibility to AHCCCS, to insure that the required verification and supporting case documentation is present.

R9-22-339. Newborn Eligibility

A. A newborn whose mother has been determined indigent or medically needy shall be provided not less than 30 consecutive days nor more than 60 consecutive days of AHCCCS eligibility. Eligibility shall begin on the date of birth. Nothing contained in this subsection shall be construed to prevent a newborn from obtaining additional eligibility and enrollment as otherwise provided for in this Article.

B. A newborn of a categorically eligible mother shall be AHCCCS eligible from the date of birth through the end of the month in which the newborn's 1st birthday occurs, as long as the newborn remains in the mother's household in Arizona.

C. If AHCCCS receives notification of the baby's birth from the appropriate eligibility agency, contractor, or hospital, the newborn shall be enrolled according to R9-22-333, R9-22-334, or R9-22-342 whichever is applicable.

R9-22-340. Eligibility and enrollment for pregnant women

A. The county eligibility office shall provide for continuous eligibility of a pregnant woman who is determined eligible as indigent or medically needy and whose condition of pregnancy is clinically verified in writing by a health care professional licensed pursuant to Title 32, Chapter 13, 15, 17 or 25 or Title 36, Chapter 6, Article 7 until the last day of the month after the month of the estimated date of delivery.

B. As a condition of continuous eligibility and enrollment, the pregnant woman must notify her county of residence and provide necessary verification of her pregnancy and estimated date of delivery prior to the end of her certification period. If the pregnant woman subsequently provides verification to the county that her estimated date of delivery has changed, her certification period shall be adjusted accordingly.

C. The County Eligibility Office shall notify the Administration that a pregnant woman qualifies for continuous eligibility and enrollment prior to the end of her certification period. The County Eligibility Office also shall notify the Administration of any subsequent adjustment to the pregnant woman's certification period.

D. The pregnant woman shall notify the county of any change in her financial or clinical status that might disqualify her from continuous eligibility and enrollment.

E. The child who is born to a woman under continuous eligibility and enrollment shall also be enrolled with the woman's contractor in accordance with R9-22-339.

R9-22-341. Priority processing of medically needy and indigent applications of applicants facing a loss of categorically eligible status as a result of the termination of SSI benefits

A. Applicants may appeal to the Administration from the proposed termination of their categorical coverage. They may also apply for medically needy or indigent coverage whether or not they choose to appeal such proposed termination.

B. Within ten days after the date on which the Administration receives notification from the Social Security Administration that a applicant currently eligible as an SSI recipient is ineligible for receipt of SSI, the Administration shall mail to such applicant a notice of proposed termination of categorical eligibility and a pre-printed, postage-prepaid postcard. The postcard may be used by the applicant to initiate the eligibility determination process for indigent or medically needy coverage.

C. A applicant facing the loss of categorical eligibility status, as a result of the termination of SSI benefits, who has mailed to his county of residence the pre-printed postcard requesting an appointment, signed and postmarked within seven days after the date of the notice of proposed termination, shall be processed as follows:

1. If the pre-printed postcard indicates that the applicant may be in immediate or ongoing need of medical care, the county shall determine the applicant's indigent or medically needy eligibility within 20 days after the date of the postmark on the postcard. If the postmark date is not legible, the 20-day period shall commence on the date that the county receives the postcard.
2. If the pre-printed postcard indicates that the applicant believes he or she may need a medical examination or medical care in the next 30 days or more, the county shall determine the applicant's indigent or medically needy eligibility within 30 days after the date of the postmark on the postcard. If the postmark date is not legible, the 30-day period shall commence on the date that the county receives the postcard.
3. If the circumstances described in subsections (C), paragraphs (1) or (2) of this Section are not applicable, the county shall determine the applicant's indigent or medically needy eligibility with 60 days after the date of the postmark on the postcard. If the postmark date is not legible, the 60-day period shall commence on the date that the county receives the postcard.
4. When the county receives a timely mailed, preprinted postcard, the county shall initiate the indigent and medically needy eligibility determination process by mailing to the applicant who has requested such a determination a notice, setting forth:
   a. The fact that the county is prepared to take the indigent and medically needy application and interview the applicant.
   b. At least one appointment date and time at which county eligibility staff will take the applicant's application and interview the applicant.
   c. An instruction that the applicant should immediately contact county eligibility staff to select one of the interview dates and times thus offered him or her, or arrange, if possible, an alternative, permissible date and time.
   d. A warning that failure to attend an appointment at any of the specified dates and times, without arranging an alternative, may prevent county eligibility staff from making an eligibility determination within the time and in the manner otherwise required by the applicant's request.
   e. A reminder that the applicant should review the material on verification of eligibility information previously received from the Administration, and immediately make every effort to obtain the documentation specified therein for presentation at his or her interview.
   f. An instruction that the applicant should also bring to the interview the notice of proposed termination of categorical eligibility that he or she previously received from the Administration.
5. County eligibility staff shall arrange appointments and send the notice required by subsection (C), paragraph (4) of this Section at times that not only permit eligibility determinations within the time limits established by subsection (C), paragraphs (1) through (3) of this Section, but are not so near in time to the postmark date on the postcard that attending appointments on the days specified in the notice imposes an undue burden on the applicant.

D. The notice of proposed termination of categorical eligibility shall include the applicant's name, social security number and date of birth. If the applicant presents the notice at his or her interview as requested, it shall in all cases be deemed sufficient evidence of Arizona residency, date of birth and social security number. The county eligibility staff shall make a copy of the notice and include it in the case record. The original or copy of the notice presented by the applicant shall be returned to the applicant.

E. Except as otherwise provided in this Section, all requirements of this Article applicable to priority applications for medically needy and indigent coverage shall apply.

R9-22-342. Newborn Enrollment

A. A newborn baby is eligible for AHCCCS as specified in R9-22-339 only when the mother is eligible for AHCCCS covered services on the date of the newborn baby's birth.

B. The Contractor is responsible for notifying the Administration of a child's birth to an enrolled member. For capitation purposes, as specified in R9-22-707 and as provided in contract, the effective date of the newborn's enrollment is the date the Administration receives notification.

C. The Administration shall enroll a newborn baby with the contractor with whom the mother is enrolled on the date the Administration receives notification of the newborn baby's birth.

R9-22-343. Eligibility for State Emergency Services

A. Filing unit. The AHCCCS family household for state emergency services shall be established pursuant to R9-22-307.

B. Residency. No one shall be eligible for state emergency services who does not meet the residency requirements described in R9-22-301.

C. United States citizenship or alien status. United States citizenship and the alienage requirements of 42 CFR 435.406(a), March 14, 1991, incorporated by reference herein and on file with the Office of the Secretary of State, are not conditions of eligibility for state emergency services. An applicant for indigent, medically needy, or eligible low-income child services may receive coverage for state or federal emergency services, if otherwise eligible, pending compliance with the citizenship or alien status verification requirements.

D. Income. The AHCCCS family household income shall be determined pursuant to R9-22-321 and R9-22-322.

E. Resources. The AHCCCS family resources shall be determined pursuant to R9-22-323, R9-22-324, R9-22-325, and R9-22-329.

F. Responsibility of the head of household. The head of household for a state emergency services applicant shall have the same responsibilities as described in R9-22-311 and shall be required to sign the Statement of Truth described in R9-22-312.

G. Initiating the application. Routine and priority applications for state emergency services shall be initiated pursuant to R9-22-306.

H. Mandatory dual application and referral to DES.

1. A applicant applying for state emergency services who is potentially eligible for federal emergency services shall concurrently apply for federal emergency services.
2. A applicant who is potentially eligible for federal emergency services shall not be eligible for state emergency services if the applicant refuses to cooperate with the completion of the federal application process.
3. When the household includes a applicant who must concurrently apply for Title XIX, the application and all verification and documentation contained in the county case file shall be forwarded to DES by the third working day following the completion of an eligibility determination of any household member who is hospitalized and potentially eligible for Title XIX, or the first working day after 30 days from the date of application, whichever is earlier.
4. An applicant for state emergency services who is potentially eligible for federal emergency services shall not be certified or recertified for AHCCCS coverage until federal emergency services have been denied, unless the applicant is hospitalized.

I. Verification requirements.

1. An applicant for state emergency services shall not be approved for emergency services coverage until the verification requirements pursuant to R9-22-327 have been met, except the verification requirements related to U.S. citizenship and lawful resident alien status.
2. A member's declaration shall be accepted as verification of undocumented alien status or of nonimmigrant alien status for coverage of state emergency services.
3. Verification of receipt of or need for medical emergency services is required prior to certification or recertification for state emergency services coverage.
   a. A member's declaration is acceptable as verification for certifications through the end of the calendar month of approval or through the end of the following month when the certification is made during the last five days of the month.
   b. Documented or collateral verification from a medical provider is required prior to a longer certification period or prior to an extension of the certification period.

J. Face-to-face interview. During the face-to-face interview which shall be conducted pursuant to R9-22-310, the county eligibility worker shall additionally explain the following to an applicant for state emergency assistance:

1. The requirement to file a federal application and cooperate with the federal application process when the applicant is potentially eligible for federal emergency services;
2. The medical coverage is limited to emergency services only;
3. The requirement to provide verification of emergency medical services to be certified beyond the end of the month of approval, and
4. The procedure for having the certification extended.

K. Adverse action.

1. The denial or discontinuance reasons for state emergency services shall be the same as those listed in R9-22-318 with two exceptions:
   a. Failure to meet the United States citizenship or alien status requirement is not a valid reason for denial or discontinuance of state emergency services, and
   b. Nonreceipt of or absence of need for emergency services is a valid for denial or discontinuance of state emergency services.
2. The notification and effective date of discontinuance shall be in accordance with R9-22-318.
3. The head of household of a family which includes any applicant who has been denied state emergency services coverage or whose coverage has been discontinued may request a hearing pursuant to Article 8.

L. Certification of eligibility.

1. The initial certification period for a woman who is verified to be pregnant and who is eligible for state emergency services shall begin on the date of determination and end on the last day of the third calendar month following the month of certification, but in no case later than the last day of the month following the month in which the pregnancy terminated.
2. The initial certification period for other applicants who are eligible for state emergency services shall begin on the date of determination and end on the last day of the calendar month of determination or, if certified during the last five days of the month, the certification may end on the last day of the following month. The certification period may end on the last day of the first, second, or third calendar month following the month of determination if a medical provider verified that the emergency episode will continue for at least one day during the month.
3. After the initial period, coverage may be extended using the re-evaluation process in blocks of up to three additional calendar months when the applicant continues to meet the eligibility criteria and a medical provider verifies the receipt of or expected receipt of emergency medical services during the month. Prospective eligibility shall not be granted for more than three prospective months at one time. Except for pregnant women who may be certified through the month following the month in which the pregnancy is terminated, the certification of state emergency services coverage may be extended for no more than a total of six months from an initial or recertification eligibility determination using the re-evaluation process.
4. In no event shall the certification period of a state emergency services applicant who would have been eligible as an eligible low-income child but for failure to meet the citizenship or alien status requirements in accordance with R9-22-302 extend beyond the last day of the birthday month of the child's 14th birthday, as specified in A.R.S. § 36-2905.03.
5. Retroactive coverage of state emergency services shall commence no earlier than two days prior to the date of determination and shall only be during months in which emergency services are incurred.

M. Notification requirements.
1. Applicants for or recipients of state emergency services shall be notified of eligibility or ineligibility pursuant to R9-22-316.
2. Communication of eligibility to the Administration for state emergency services shall occur pursuant to R9-22-334.
3. A verification review may be conducted by the Director pursuant to R9-22-338.
4. The provider notification requirements in R9-22-308 apply to applicants for state emergency services.

N. Interim changes and recertification.
1. A applicant certified for state emergency services shall report interim changes pursuant to R9-22-330.
2. When an AHCCCS family household member who does not meet the citizenship or alien status requirements for coverage as an indigent or medically needy applicant or as an eligible low-income child requests state emergency services during the certification period of other AHCCCS family household members, a re-evaluation of the family household shall be completed pursuant to R9-22-331 prior to certifying the applicant for state emergency services.
3. A complete redetermination of eligibility shall be completed no less than every six months for applicants certified for state emergency services who are experiencing a lengthy emergency episode, except for pregnant women who may be certified through the month following the month in which the pregnancy terminated.

R9-22-344. Eligibility for Medicare Beneficiaries

A. Eligibility Criteria. Effective July 1, 1996, applicants who either receive or may receive Medicare Part A benefits during the indigent or medically needy certification period shall have eligibility determined according to the following process, when applying for coverage as an indigent or medically needy applicant pursuant to A.R.S. §§ 11-297 and 36-2905:
1. Applicants who are enrolled in a Medicare HMO and apply or reapply for eligibility shall not be approved for coverage as an indigent or medically needy applicant.
2. Applicants who have Medicare Part A and B benefits and who are not enrolled in a Medicare HMO, but who are eligible to be enrolled in a Medicare HMO in their county of residence, shall be certified as indigent or medically needy for a period of time that is no longer than the month of certification, plus 2 additional calendar months.
3. Applicants who are eligible for Medicare Part A benefits, but who are not receiving Medicare Part B benefits, shall be advised to apply for Medicare Part B Medicare benefits during the first general Medicare enrollment period as specified in 42 CFR 406 and 407. Individuals shall not be approved for coverage as an indigent or medically need applicant after the date that Medicare Part B benefits are available, or would have been available, if the applicant had applied for Medicare Part B benefits during the Medicare general enrollment period.
4. Applicants who become eligible for Medicare Part A and Medicare Part B benefits during the indigent or medically needy certification period, including applicants who have been disabled for 24 months, and who are entitled to enroll in Medicare as specified in 42 CFR 406.12, shall be advised to apply for those benefits during the initial Medicare enrollment period as specified in 42 CFR 406 and 407. Individuals shall not be approved for coverage as an indigent or medically needy applicant after the Medicare Part A and Part B benefits are effective, or would have been effective if the applicant had applied for Medicare Part B benefits during the initial enrollment period, allowing a minimum of 2 months from the last day of the initial enrollment period to provide an opportunity to enroll in a Medicare HMO.
5. Exception: This Section does not apply to the following individuals if all other eligibility requirements for A.R.S. §§ 11-297 or 36-2905 are met:
   a. Applicants who have had an organ transplant requiring immunosuppressant prescription drugs; or
   b. Applicants who are prohibited from enrolling in a Medicare HMO due to pre-existing medical conditions or receipt of Medicare hospice services; or
   c. Applicants who reside in a county that does not have a Medicare HMO operating in that county, unless the applicant is enrolled with a Medicare HMO based outside the county of residence.

B. Undue Hardship
1. Individuals may apply to the Administration for an undue hardship reimbursement of Medicare Part B premiums paid by the individual to the Social Security Administration if all of the following criteria are met:
   a. The individual has been determined ineligible for benefits pursuant to A.R.S. §§ 11-297 or 36-2905 due solely to the Medicare restrictions prescribed in this Section;
   b. The individual received Medicare Part A benefits as specified in 42 CFR 406 and 407 prior to July 1, 1996;
   c. The individual did not have Medicare Part B coverage as of July 1, 1996;
   d. The individual has applied and has been determined ineligible for the Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary (Quasi-qualified Medicare beneficiary) program, as defined in A.R.S. § 36-2970 et. seq. due solely to excess income; and
   e. The individual has applied to the Social Security Administration for Medicare Part B benefits.
2. The Administration shall establish a process to reimburse the Medicare Part B premiums directly to the individual who receives approval for an undue hardship according to this Section.
3. Once every 6 months, the Administration shall review the status of each individual who has been granted an undue hardship according to this Section and may approve additional 6-month extensions of the undue hardship provided that the individual continues to meet all criteria established in this Section.

C. Voluntary Discontinuance of Medicare Part B Benefits. An individual who has Medicare Part B benefits and who is ineligible for indigent or medically needy benefits pursuant to this Section, shall not be determined eligible for indigent or medically needy benefits at a later date if the individual voluntarily discontinues Part B Medicare benefits.

D. AHCCCS Payment of Medicare HMO Monthly Premiums
1. The Administration may pay the Medicare Health Maintenance Organizations (HMO) premiums for individuals who are ineligible for indigent or medically needy benefits, as specified in this Section, when all Medicare HMOs operating in the individual's county of residence charge a monthly premium. The Administration will pay the premium only if all of the following criteria are met:

~~a. The individual is receiving Medicare Parts A and B as specified in 42 CFR 406 and 407.~~
~~b. The individual has been determined ineligible for benefits pursuant to A.R.S. §§ 11-297 or 36-2905 due solely to the Medicare restrictions prescribed in this Section.~~
~~c. The individual is ineligible for the Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary (Quasi-qualified Medicare beneficiary) program as defined in A.R.S. § 36-2970 et. seq. due solely to excess income.~~

~~2. The Administration will pay no more than the lowest Medicare HMO monthly premium available when there is more than 1 Medicare HMO in the individual's county of residence.~~

~~3. The Administration shall not pay the monthly Medicare HMO premium when coverage from a premium-free Medicare HMO becomes available in the individual's county of residence.~~

~~4. Once every 6 months, the individual shall apply to the Administration for a redetermination of eligibility according to this Section.~~

ARTICLE 14. TITLE IV-A RELATED ELIGIBILITY

R9-22-1401. Scope and Applicability

A. This Article applies to all eligibility coverage groups listed in R9-22-1406 unless otherwise specified.

B. To qualify for medical assistance under this Article, a person shall be:
1. A child under age 18, or age 18 and meeting student requirements defined in R9-22-1406,
2. A parent or nonparent caretaker relative of a deprived child if the child meets the requirement in subsection (B)(1), or
3. A pregnant woman.

C. The eligibility requirements for a person who is age 65 or older, blind, or disabled are specified in 9 A.A.C. 22, Article 15.

R9-22-1402. Agency Responsible for Determining Eligibility

The Department shall determine eligibility under the provisions of this Article for all persons listed in R9-22-1401(B) who apply for medical assistance under this Article.

R9-22 -1403. Confidentiality

The confidentiality provisions in R6-12-102 apply to this Article.

R9-22-1404. Case Record

A. The Department shall maintain a case record for each applicant and recipient of medical assistance.

B. The case record shall contain all documentation collected or prepared by the Department in evaluating and determining eligibility.

C. The Department shall keep the case record for 3 years after the date of the last Notice of Action sent by the Department denying or terminating eligibility.

R9-22-1405. Manuals

FAA shall maintain a copy of the Medical Assistance Program eligibility policy material in each FAA office and make the material available for public inspection and copying during regular business hours.

R9-22-1406. Eligibility Coverage Groups and an Eligible Person

A. General eligibility. The Department shall evaluate eligibility under this Article for any person listed in R9-22-1401(B). To be eligible, a person shall meet all the eligibility requirements in this Article, except as otherwise specified. The coverage groups defined in this Section are authorized in A.R.S § 36-2901.4(b).

B. The 1931 coverage group.
1. The 1931 groups includes families who meet the eligibility provisions of Section 1931 of the Social Security Act, 42 U.S.C. 1396u-1, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. If determining eligibility under the 1931 group, the Department shall include the following persons, if living together, in the assistance unit:
   a. A dependent child under age 18;
   b. A dependent child age 18 who is:
      i. A full-time student in a secondary school, or the equivalent level of vocational or technical training school, as provided in subsection (B)(5); and
      ii. Reasonably expected to complete the education or training before age 19;
   c. The parent of a dependent child; and
   d. A dependent child's sibling who is:
      i. Under age 18; or
      ii. Age 18 and meets the student requirements under subsection (B)(2)(b).
3. The Department may include a nonparent caretaker relative meeting the requirements specified in R9-22-1418 if:
   a. The nonparent caretaker relative provides a dependent child with physical care, support, guidance, and control; and
   b. The parent of a dependent child:
      i. Does not live in the nonparent caretaker relative's home;
      ii. Lives with the nonparent caretaker relative but is also a dependent child; or
      iii. Lives with the nonparent caretaker relative but cannot function as a parent due to a physical or mental impairment.
4. An applicant in the last trimester of pregnancy, with no other dependent children, may be eligible for medical assistance under the 1931 group, as though the child was already born. The Department shall consider the unborn child to be a dependent child.
5. Full-time school attendance as specified in subsection (B)(2)(b) means:
   a. For secondary school, attendance which the school defines as full-time; or
   b. For a vocational or technical school which:
      i. Includes shop practicum, attendance is 30 hours per week; or
      ii. Does not include shop practicum, attendance is 25 hours per week.
6. The Department shall verify school attendance as provided in subsection (B)(2)(b), through school records to establish full-time attendance status and expected date of graduation.

C. 4-month-continued-coverage group. If the collection of court ordered spousal maintenance, division of income, alimony, or child support under Title IV-D of the Act results in ineligibility for medical assistance under the 1931 group, the Department shall provide 4 consecutive calendar months of medical assistance under the provisions of Section 1931(c) of

the Social Security Act, 42 U.S.C. 1396u-1, July 1, 1997, and 42 CFR 435.115(f) and (g), December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

D. Title IV-E adoption subsidy or Title IV-E foster care coverage groups.
   1. The Title IV-E coverage groups include a child:
      a. For whom an adoption assistance agreement is in effect under Title IV-E of the Act; or
      b. Who receives a foster care maintenance payment under Title IV-E of the Act;
   2. A child meeting the provisions of subsection (D)(1) shall also meet the eligibility requirements specified in R9-22-1422 through R9-22-1424.

E. State adoption subsidy coverage group. The state adoption subsidy coverage group includes a child meeting the provisions of 42 CFR 435.227, December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

F. Transitional medical assistance (TMA) group.
   1. Except as provided in subsection (F)(2), the Department shall determine initial and ongoing eligibility in the TMA group for the 1931 assistance unit who meets the eligibility provisions of 42 U.S.C. 1396a(e)(1), July 1, 1997, and 42 U.S.C. 1396r-6, August 5, 1997, except for the options defined in Section 1925(a)(4)(B) of the Act, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.
   2. The Department may determine the assistance unit eligible for TMA for a period not to exceed:
      a. 24 months; or
      b. 12 months, if the Department assigns the TMA case to a control group as provided in R6-12-105(A), (B), and (C); and
   3. The Department shall collect semi-annual income reports in lieu of quarterly income reports.
   4. To qualify for medical assistance under TMA, a person shall be:
      a. An eligible member of a 1931 family at the time eligibility changes from the 1931 group to the TMA group under subsection (F)(1); or
      b. A person who moves into the household and can be included in the TMA assistance unit specified in R9-22-1419.

G. 210 coverage group. To be eligible for the 210 group, a person shall meet all the eligibility requirements for the 210 group defined in this Article and shall be:
   1. A caretaker relative who is a natural or adoptive parent meeting the requirements of R9-22-1418 or who is a nonparent caretaker relative meeting the requirements of subsection (B)(3); or
   2. A dependent child, age 18, who meets the student requirements of subsection (B)(2)(b).

H. Ribicoff group. The Ribicoff group includes a child under age 18 who meets all the eligibility requirements under this Article except for R9-22-1418 and R9-22-1420.

I. S.O.B.R.A. FPL pregnant woman coverage group.
   1. The S.O.B.R.A. FPL pregnant woman group provides medical assistance through the postpartum period, as specified in R9-22-1434, to a pregnant woman whose monthly income does not exceed 140% of the FPL income standard.
   2. A change in income during the time a woman is eligible for and receiving medical assistance under this subsection shall not affect the woman's continued eligibility for the S.O.B.R.A. FPL pregnant woman group.

J. S.O.B.R.A. FPL children coverage group. The S.O.B.R.A. FPL children group includes children born on or after October 1, 1983, whose monthly income does not exceed the following FPL income standard:
   1. For children under age 1, 140% of the FPL;
   2. For children age 1 through age 5, 133% of the FPL; and
   3. For children age 6 and over, 100% of the FPL.

K. Deemed newborn group. The deemed newborn group includes children meeting the requirements specified in R9-22-1433.

L. Guaranteed enrollment coverage group. The guaranteed enrollment group includes persons meeting the requirements specified in R9-22-1704.

R9-22-1407. Application

A. Right to apply. A person may apply for medical assistance by submitting a Department-approved application to any FAA office or outstation location as specified in subsection (C).

B. Who may apply for the applicant. The applicant, the applicant's parent, the applicant's legal or authorized representative, or someone acting on behalf of the applicant may file the application.

C. Applications available at outstation locations. An applicant may file an application for medical assistance at 1 of the following locations:
   1. A county eligibility office as provided in A.R.S. § 36-2905. The Department shall accept the county's application form as a valid application for a S.O.B.R.A. FPL pregnant woman and a S.O.B.R.A. FPL child specified in R9-22-1406(I) and (J).
   2. A BHS site as provided in Laws 1991, Chapter 213, § 2.
   3. A CRS site as provided in Laws 1991, Chapter 213, § 21.
   4. A Baby Arizona approved provider's office if the applicant is a S.O.B.R.A. FPL pregnant woman defined in R9-22-1406(I).
   5. A FQHC or disproportionate share hospital as required by 42 CFR 435.904, October 24, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   6. Any other site determined by the Department or Administration.

D. Application date. The application date is the date a FAA office or other approved location listed in subsection (C) receives an application. An application shall contain:
   1. The legible name and address of a person requesting assistance and each person for whom assistance is requested, and
   2. The signature of an person making application as specified in subsection (B).

E. Complete application. A complete application shall contain:
   1. Information listed in subsection (D),
   2. The names of all persons living with the applicant and the relationship of those persons to the applicant, and
   3. All eligibility information requested on an application form.

F. Application for cash. An application filed with the Department for cash assistance under 6 A.A.C. 12 is an application for medical assistance under this Article.

G. Deceased applicant. An application meeting the provisions of this Section, filed on behalf of a deceased applicant is an application if the application is filed no later than the 3rd month following the applicant's date of death.

R9-22-1408. Applicant and Recipient Responsibility

A. A person shall cooperate with the Department as a condition of initial and continuing eligibility.

B. The person shall:
1. Give the Department complete and truthful information;
2. Comply with the requirements of R9-22-1411 and R9-22-1415;
3. Comply with the verification requirements specified in R9-22-1413;
4. Inform the Department of the following changes which may affect eligibility within 10 days from the date the person knows of the change:
   a. A change in address,
   b. A change in the household's composition,
   c. A change in income,
   d. A change in resources,
   e. A change in Arizona state residency,
   f. A change in citizenship or alien status,
   g. A change in 1st-or 3rd-party liability which may contribute to the payment of all or a portion of the person's medical costs, and
   h. Any other change that may affect the person's eligibility;
5. Comply with the Department's procedural requirements;
6. Cooperate with the DCSE in establishing paternity and enforcing medical support obligations, unless the person shows good cause as provided in R9-22-1422; and
7. Provide information concerning 3rd-party coverage for medical care.

C. The person shall:
1. Send to the Department any medical support payments received by the person while the person is eligible for medical assistance, and
2. Comply with the quality control review process.

D. The Department may deny an application for or discontinue eligibility of medical assistance if the person fails or refuses to cooperate.

R9-22-1409. Death of an Applicant

A. If an applicant dies while an application is pending, the Department shall complete an eligibility determination for all applicants listed on the application, including the deceased applicant.

B. The Department shall complete an eligibility determination on an application filed on behalf of a deceased applicant as provided in R9-22-1407.

R9-22-1410. Withdrawal of Application

A. An applicant may withdraw an application at any time before the Department completes an eligibility determination by making an oral or written request for withdrawal.

B. If an applicant orally requests to withdraw the application, the Department shall:
1. Document the date of the request,
2. Document the name of the applicant for whom the withdrawal applies,
3. Deny the application, and
4. Notify the applicant of the denial following the notice requirements specified in R9-22-1414.

C. An applicant may withdraw an application in writing by:
1. Completing a Department-approved voluntary withdrawal form; or
2. Submitting a written, signed, and dated, request to withdraw the application.

D. When the Department receives the written request for withdrawal, the Department shall deny the application and notify the applicant of the denial under R9-22-1414.

E. The effective date of the withdrawal is the date of the application.

R9-22-1411. Initial Eligibility Interview

A. Upon receipt of an application defined in R9-22-1407(D), the Department shall:
1. Schedule an initial eligibility interview, and
2. Provide the applicant a written notice of the scheduled interview.

B. If a homebound applicant requests a home visit or a Department representative believes that a home visit will avoid an eligibility determination error, the Department shall:
1. Schedule a home visit, and
2. Mail the applicant written notice of a scheduled home visit at least 7 days before the date of the visit.

C. The applicant or the applicant's representative shall attend the interview.

D. During the interview, a Department representative shall:
1. Help the applicant complete the application form;
2. Witness the signature of the applicant or the applicant's representative as provided in R9-22-1407;
3. Provide the applicant with written information explaining:
   a. The eligibility and verification requirements of the medical assistance program;
   b. The requirement that the applicant obtain and provide a SSN to the Department;
   c. How the Department uses the SSN;
   d. The Department's practice of exchanging eligibility and income information through the SVES;
   e The applicant's rights and responsibilities, including the right to appeal an adverse action;
   f. The requirement to report a change listed in R9-22-1408 no later than 10 days from the date the applicant knows of the change;
   g. The eligibility review process;
   h. The program coverage and the types of services available under each program;
   i. The family planning services available through AHCCCS health plans;
   j. The AHCCCS pre-enrollment process; and
   k. Availability of continued medical assistance under the TMA group defined in R9-22-1406;
4. Review the penalties for perjury and fraud printed on the application;
5. Explain who is included in an assistance unit;
6. Review any verification information provided by the applicant and give the applicant a written list of additional verification that the applicant shall provide to the Department within the time-frame listed in R9-22-1413;
7. Explain the applicant's responsibilities listed in R9-22-1408; and
8. Review all reporting requirements and explain that the person may lose the earned income disregards defined in R9-22-1429 if the person fails to report changes timely.

E. If the applicant misses a scheduled appointment for an interview, or is not home for the scheduled home visit, the Department shall schedule a 2nd interview only if the applicant

requests a 2nd interview before close of business on the day of the missed appointment.

F. The Department shall deny the application if the applicant fails to request a 2nd appointment under subsection (E) or if the applicant misses a 2nd scheduled appointment, unless the applicant establishes good cause for missing the appointment.

G. The Department:
1. May conduct unscheduled home visits to gather information or to verify information previously provided by an applicant, and
2. Shall not deny an application or terminate medical assistance if the applicant is not home for an unscheduled visit.

R9-22-1412. Withdrawal from the Medical Assistance Program

A. A person or the person's legal or authorized representative may withdraw from the program at any time by making an oral or written request for withdrawal and providing the Department with:
1. The reason for the withdrawal,
2. The date the request is effective, and
3. The name of the person for whom medical assistance is being withdrawn.

B. If the request to withdraw does not identify a specific person, the Department shall apply the request to the entire assistance unit and terminate eligibility.

C. If the request to withdraw does not include all the members of the assistance unit, the Department shall redetermine eligibility for the remaining members under this Article.

D. The Department shall process the withdrawal action and send the recipient adequate notice as provided in R9-22-1416.

R9-22-1413. Verification of Eligibility Information

A. The applicant or recipient has the primary responsibility to provide the Department with verification for all information necessary to complete the determination of eligibility at the time of application, review, or interim change.

B. The Department may assist a person in obtaining verification if the person requests help.

C. A person shall provide the Department with all requested verification no later than 10 days from the date of a written request for the information. If a person does not timely provide the requested information, the Department may deny the application or discontinue eligibility for medical assistance.

D. The Department shall obtain independent verification or corroboration of information provided by the person to determine eligibility, or if required by law.

E. The Department may verify or corroborate information by any means including:
1. Contacting 3rd-parties,
2. Making home visits as provided in R9-22-1411,
3. Requiring written documentation from the person, and
4. Conducting a computer data match through SVES.

F. The application form shall advise the person that the Department may contact 3rd-parties for information.

R9-22-1414. Processing the Application - Approvals and Denials

A. Application processing time. The Department shall complete an eligibility determination within 45 days after the application date defined in R9-22-1407(D), unless:
1. The application is withdrawn;
2. The Department denies the application because the Department cannot locate the applicant;
3. There is a delay resulting from a Department request for additional verification information as provided in R9-22-1413(C); or
4. The applicant is applying under the S.O.B.R.A. FPL pregnant woman group described in R9-22-1406. The Department shall complete S.O.B.R.A. FPL pregnant woman applications within 20 days after the application date.

B. Approval. If the applicant meets all the eligibility requirements of this Article, the Department shall approve the application and send the applicant an approval notice which includes:
1. The name of each approved applicant,
2. The effective date of eligibility defined in R9-22-1431 for each approved applicant,
3. The eligible months in the prior quarter period described in R9-22-1432, and
4. The applicant's appeal rights described in R9-22-1436.

C. Denial. The Department shall deny an application and send an applicant a denial notice if an applicant fails to meet all the eligibility requirements of this Article. The Department may deny an application and send an applicant a denial notice if an applicant fails to:
1. Complete the application or an eligibility interview required in R9-22-1411,
2. Submit all required verification information no later than 10 days from the date of a written request for verification, or
3. Cooperate with the requirements listed in R9-22-1408.

D. Denial notice.
1. The notice shall contain:
   a. The name of each ineligible applicant;
   b. The specific reason why the applicant is ineligible;
   c. The income and resource calculations compared to the income or resource standard applicable to the size of the assistance unit when the reason for the denial is due to the applicant's income or resources exceeding the applicable standard;
   d. The legal citations supporting the reason for the ineligibility;
   e. The physical location where the applicant can review the legal citations in subsection (D)(1)(d);
   f. The month of ineligibility including the months during the prior quarter, described in R9-22-1432, if a determination of prior quarter eligibility, completed under R9-22-1432, resulted in a denial for all months in the prior quarter; and
   g. The applicant's right to appeal the decision and request a hearing as provided in R9-22-1436.
2. The Department shall mail the notice, 1st class, postage prepaid, to the applicant's last known mailing address.

R9-22-1415. Review

A. The Department shall complete a review of each person's continued eligibility for medical assistance at least once every 6 months, except for a S.O.B.R.A. FPL pregnant woman.

B. The Department shall complete a review of a S.O.B.R.A. FPL pregnant woman following the termination of her pregnancy.

C. The Department may complete a review:
1. Any time the Department receives information that a person's circumstances have changed and which may affect the person's eligibility, or

2. To bring a review date in line with a 6-month review date for the Department's cash assistance or Food Stamps programs.

D. For a 6-month review, the Department shall:
1. Mail the person a notice advising the person of the need for a review at least 30 days before the 6-month review date;
2. Schedule and conduct a review interview in the same manner as an initial interview; and
3. Verify the assistance unit's income and resources, any eligibility factors which have changed, and any eligibility factors for which the Department has information suggesting a change.

E. The notice in subsection (D)(1), shall instruct the person to:
1. Contact the Department and schedule an interview to complete the review by the date specified on the review notice,
2. Complete the review application and interview, and
3. Provide verification required in R9-22-1413.

F. If a person continues to meet all eligibility requirements, the Department shall authorize continued eligibility and notify the person of continued eligibility.

G. The Department shall discontinue eligibility and shall notify the person of the discontinuance specified in R9-22-1416 and R9-22-1436 if the person:
1. Fails to comply with the review,
2. Fails to comply with the requirements specified in R9-22-1411 without good cause, or
3. Does not meet the eligibility requirements.

R9-22-1416. Notice of Termination Action

A. Notice requirement. If the Department determines the recipient ineligible for medical assistance, the Department shall:
1. Send the person notice under subsections (B) and (C); and
2. Mail the notice, 1st class, postage prepaid, to the person's last known mailing address.

B. Content of notice. The notice shall contain:
1. The name of each ineligible recipient;
2. The specific reason why the recipient is ineligible;
3. The income and resource calculations compared to the income or resource standard applicable to the size of the recipient's assistance unit when the reason for the discontinuance is due to the recipient's excess income or resources;
4. The legal citations supporting the reason for the ineligibility;
5. The physical location where the recipient can review the legal citations in subsection(B)(4);
6. The date the discontinuance is effective; and
7. The recipient's appeal rights and right to continued medical assistance pending appeal provided in R9-22-1436.

C. Timing of notice.
1. Except as provided in subsection(C)(2), the Department shall mail the person an advance Notice of Action for an adverse action no later than 10 days before the effective date of the adverse action.
2. The Department may mail an adverse Notice of Action no later than the effective date of the adverse action if the Department:
a. Receives a clear written statement signed by a person who wishes to withdraw from the program and indicates an understanding that the information provided will result in a discontinuance of medical assistance;
b. Receives verification that the person is an inmate of a penal institution as defined in 42 CFR 435.1009, July 1, 1995, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments;
c. Has documented information confirming the death of a person;
d. Receives returned mail with no forwarding address from the post office and the person's whereabouts are unknown; or
e. Verifies that the person has been approved for Medicaid coverage by another state.

R9-22-1417. Reinstatement of Medical Assistance

A. The Department shall only reinstate eligibility without a new application if:
1. The discontinuance was due to Department error, or
2. The Department receives a court order or administrative hearing decision mandating reinstatement.

B. If the Department reinstates eligibility to a person who did not receive 6-month review required under R9-22-1415 due to the discontinuance of medical assistance, the Department shall conduct the review as soon as possible following reinstatement.

R9-22-1418. Dependent Child Living With Specified Relative

A. The eligibility requirement that a dependent child live with a specified relative applies only to the 1931 and 210 coverage groups described in R9-22-1406(B) and R9-22-1406(G).

B. A specified relative is:
1. A natural or adoptive parent;
2. A stepparent and any other nonparent relative related by blood or adoption including:
a. Grandmother;
b. Grandfather;
c. Brother;
d. Sister;
e. Uncle;
f. Aunt;
g. 1st cousin;
h. Nephew;
i. Niece;
j. Persons of preceding generations as denoted by prefixes grand or great, or to the 5th degree grandparent; and
k. 1st cousins once removed; or
3. A spouse of any person named in subsections (B)(1) or (B)(2), even if death or divorce terminates the marriage.

C. The Department shall not determine a child or specified relative ineligible solely because:
1. The dependent child is under the jurisdiction of a court;
2. An agency or applicant unrelated to the child has legal custody of the child;
3. A specified relative maintains a home for the child and exercises responsibility for the care and supervision of the child who is temporarily absent from the home for 1 of the following reasons:
a. The child, by court order, visits a noncustodial parent for a period not to exceed 3 consecutive months;
b. The child is visiting a parent who has a legal order awarding joint custody of the child, and the child resides with a parent who is part of the child's assistance unit for the entire calendar month;

c. The child is living in a Department-licensed shelter which does not receive funding under Title IV-A or Title IV-E and the Department expects the child to return to the home within 30 days;
d. During the month for which the child seeks medical assistance, the child is entering or leaving foster care funded by other than Title IV-E;
e. The child is temporarily hospitalized;
f. The child is visiting friends or other relatives for a period not to exceed 3 consecutive months; or
g. The child is attending school but returns home at least once a year; or

4. The specified relative maintains a home for the child and exercises responsibility for the care and supervision of the child, and the specified relative is temporarily absent from the home for an entire calendar month or longer for 1 of the following reasons:
a. The specified relative is temporarily hospitalized, or
b. The specified relative is attending school and intends to return home to the child.

D. The Department shall verify the required degree of relationship between the child and the child's parent or nonparent caretaker relative.

R9-22-1419. Assistance Unit

A. General requirement. This Section includes the requirements for the composition of the assistance unit for specific eligibility groups described in R9-22-1406 when the persons described in each subsection live together.
B. 1931 eligibility group.
1. The Department shall include the following persons in the assistance unit:
a. A dependent child for whom medical assistance is requested; and
b. Except as provided in subsections (B)(3):
i. A natural or adoptive parent of the dependent child; and
ii. A natural or adopted sibling who is under age 18, or age 18 and is a student as described in R9-22-1406(B);
2. The Department may include the dependent child's nonparent caretaker relative who meets the requirements specified in R9-22-1418 and R9-22-1406 when the nonparent caretaker relative also requests medical assistance;
3. The Department shall not include the following persons in the assistance unit:
a. A person who is an SSI-cash recipient; and
b. The parent or sibling of a minor parent if the minor parent is married and the minor parent's parent has relinquished all control and authority over the minor parent and no longer provides financial support to the minor parent. The Department shall not consider the married minor parent a dependent child and shall not include the married minor parent in the assistance unit of the minor parent's parent;
4. The Department shall combine more than 1 assistance unit into 1 unit if:
a. A caretaker relative applies for children who are not required to be in the same assistance unit described in subsection (B)(1)(b); and
b. The Department requires the person to be included in more than 1 assistance unit as specified in subsection (B)(1); and
5. The Department shall determine eligibility for a caretaker relative even though the only dependent child is an SSI-cash recipient or foster care child who receives foster care maintenance payments.

C. Transitional Medical Assistance (TMA) group. The Department:
1. Shall include in the TMA assistance unit eligible members of a 1931 assistance unit at the time eligibility under the 1931 eligibility group ends and the eligibility under the TMA group begins;
2. Shall add to the TMA assistance unit an eligible child's parent or sibling meeting the age requirements specified in R9-22-1406(B) and who meets the eligibility requirements under this Article.
3. Shall not add to the TMA assistance unit, a person who is currently living in the home and was living in the home at the time eligibility under the 1931 eligibility group closure and the TMA group began. For example: A stepparent with no child-in-common in the home at the time of the 1931 closure is not eligible for TMA coverage even if a child-in-common is born during a TMA eligibility period. The stepparent is not eligible for TMA even though the child-in-common may be eligible.

D. 4-month-continuing-coverage group. The Department shall include in the assistance unit eligible members of a 1931 assistance unit at the time of the 1931 closure and eligibility under the 4-month-continuing-coverage group begins.
E. Eligibility groups listed in R9-22-1406(G) through (J):
1. The following persons shall be included in the assistance unit:
a. The applicant, and if the applicant is pregnant, the applicant's unborn child;
b. The parent of the applicant, if the applicant is:
i. Under age 18, or
ii. Age 18 and is a student under R9-22-1406 if the Department evaluates eligibility under the 210 group specified in R9-22-1406(G), and
c. The applicant's spouse.
2. A parent or a spouse who is an SSI-cash recipient shall not be included in the assistance unit.

R9-22-1420. Deprivation

A. Applicability. This Section applies only to the 1931 and 210 coverage groups described in R9-22-1406(B) and (G).
B. General. Deprivation may be caused by 1 of the factors specified in subsections (C) through (F).
C. Deprivation due to continued absence.
1. Continued absence of a parent exists:
a. When the parent is out-of-the-home and the absence either interrupts or terminates the parent's functioning as a provider of support, physical care, or guidance for the child;
b. When the known or indefinite duration of the absence precludes relying on the parent's performance of the function of planning for the present support or care of the child; and
c. When the absence is for a period of 30 days or more for any reason other than those listed in subsection (C)(4).
2. In addition to subsection (C)(1), the following circumstances constitute evidence of deprivation by a parent's continued absence:
a. A parent is absent due to hospitalization, incarceration, or deportation;
b. A parent is a convicted offender who is permitted to live at home while serving a court-imposed sen-

tence of performing unpaid public or community service during the work day. The Department shall consider the parent to be out of the home for the purpose of deprivation;

c. A single parent adopts a child;

d. The child's mother and putative father both dispute paternity and there is no documentation to substantiate paternity; or

e. The parents have joint legal or physical custody of the child, but the child resides with 1 parent more than 50% of the time. The child's home will be considered to be with the primary custodial parent who has the child more than 50% of the time.

3. A child who suffers deprivation under subsection (C)(1) shall not be denied a finding of deprivation based on any 1 of the following:

a. A stepparent, nonparent caretaker relative, or adult who is not the child's parent, resides in the child's home;

b. The child's home is considered unsuitable because of neglect, abuse, or exploitation;

c. The parent or nonparent caretaker relative refuses to cooperate with the Department regarding Title IV-D medical support enforcement or collection; or

d. The absent parent visits the child.

4. A finding of continued absence shall not be established if:

a. The parent is voluntarily absent to visit friends or relatives, to seek employment, to maintain a job, to attend school or training, as long as the parent in the home and the absent parent are not separated;

b. The parent is absent due to active military duty;

c. The parents live in separate dwellings and such dwellings are considered part of a single home; or

d. 1 parent is absent from home in order to qualify the remaining family members for medical assistance.

D. Deprivation due to death. A child is deprived if either parent of the child is deceased.

E. Deprivation due to incapacity or disability.

1. A child is deprived if either the natural or adoptive parent has a physical or mental illness or impairment that:

a. Substantially decreases or eliminates the parent's ability to support or care for the child, and

b. Is expected to last for a minimum of 30 continuous days.

2. Existence of disability.

a. The local FAA eligibility interviewer shall establish incapacity, without further medical verification, if the applicant provides evidence that:

i. SSA determines the parent is eligible for Retirement, Survivors, Disability Insurance (RSDI) benefits due to blindness or disability;

ii. SSA determines the parent is eligible for SSI due to blindness or disability;

iii. Veteran's Administration determines the parent has a 100% disability;

iv. The parent's physician releases the parent from the hospital and imposes work restrictions for a specified recuperation period;

v. The parent's employer or physician requires the parent to suspend work activity due to the onset of a disability and the physician specifies a recuperation period;

vi. The parent's physician determines the parent is capable of employment only in a sheltered workshop for a specified period of time, and the parent is employed in the sheltered workshop; or

vii. A prior certification of disability is in the assistance unit's case record and is still valid to cover the period for which the assistance unit requests and will receive assistance.

b. The assistance unit shall demonstrate incapacity of a parent by providing a medical statement from a licensed physician. The statement shall include:

i. A diagnosis of the parent's medical condition,

ii. A finding that the parent has a physical or mental condition which prevents the parent from working, and

iii. An opinion concerning the duration of unemployability or a date for re-evaluation of unemployability.

3. The District Medical Consultant shall determine incapacity for all applicants not covered under subsection (E)(2).

F. Unemployment in a 2-parent household.

1. A child is deprived if the primary wage-earning parent is unemployed and the assistance unit meets the following requirements:

a. The child's natural or adoptive mother and father both reside with the child,

b. Neither parent meets the provision of subsection (E), and

c. The assistance unit's countable income does not exceed the income standards provided in R9-22-1430(B).

2. The primary wage-earner means whichever parent in a 2-parent household earned the greater amount of income in the 24-month period immediately preceding the month in which an application for medical assistance is filed.

R9-22-1421. Application for Other Benefits

An applicant or recipient shall apply for other benefits under 42 CFR 435.608, August 18, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

R9-22-1422. Assignment of Rights; Cooperation

A. General requirement. As a condition of eligibility under this Article, the person shall:

1. Assign to the state, any rights, or the rights of any other person eligible under the medical assistance program for whom a legal assignment may be made for medical support and for payment of medical care from any 3rd-party, except for Medicare benefits.

2. Comply with the cooperation requirements defined in this Section.

B. Method of assignment.

1. The method of assignment for medical support shall be made under A.R.S. § 46-407. A medical support obligation available under a court order includes any unpaid medical support obligation or support debt which has accrued at the time of the assignment.

2. The method of assignment to payment for medical care from any 1st- or 3rd-party is the application form for medical assistance. The signature on the application of the person identified in subsection (A)(1) fulfills the assignment-of-rights requirement.

C. Cooperation with the Department or the Administration for 1st-and 3rd-party payments.

1. A person described in subsection (A)(1) shall cooperate with the Department and the Administration in identifying and providing information to assist the state in pursuing any 1st or 3rd party who may be liable to pay for medical care and services provided under the medical assistance program.
2. A person shall pay to the Administration any payment received by the assistance unit that the assignment covers.

D. Cooperation with the Department for pursuing medical support.
1. Except as provided in (D)(2) and A.R.S. § 46-292(E) and (F), a parent, legal representative, or other relative who applies for medical assistance on behalf of a child shall cooperate with the Department (DCSE) to:
   a. Establish paternity, and
   b. Obtain medical support or other payments as provided in A.R.S. § 46-292(C).
2. A S.O.B.R.A. FPL pregnant woman defined in R9-22-1406 is exempt from cooperating with the Department (DCSE) in establishing paternity and obtaining medical support from a father of a child born out-of-wedlock.

E. Department responsibility. At an initial application interview and at any review, the Department shall:
1. Explain to the person:
   a. The assignment of rights;
   b. The requirement to cooperate;
   c. Good cause for not cooperating and how to establish it;
   d. The consequences of failure to cooperate with the requirements of this Section;
   e. That the Department will use the information requested in subsection (E)(2)(b) to complete data matches with potential liable parties including those described in R9-22-1413(E)(4);
   f. The requirement to send to the Department any medical support the assistance unit receives after approval for medical assistance; and
   g. The requirement to send to the Administration any payment received from any liable party for a person's medical care.
2. Obtain from the person:
   a. Health insurance information, if applicable:
      i. Name of policy holder,
      ii. Policy holder's relationship to the applicant,
      iii. SSN of the policy holder,
      iv. Name and address of the insurance company,
      v. Policy number, and
   b. The name and SSNs of absent or custodial parents of a child for whom medical assistance is requested.

F. Failure to cooperate.
1. The Department shall deny or discontinue eligibility for a person defined in subsection (B) who:
   a. Refuses to comply with the assignment requirements defined in this Section, or
   b. Refuses to cooperate as required in subsections (C) and (D).
2. The Department shall not deny medical assistance to any person who:
   a. Cannot legally assign rights under subsection (B)(2); and
   b. Who would otherwise be eligible for the program.
3. The Department shall comply with the notice and hearing requirements of R9-22-1414, R9-22-1416 and R9-22-1436 if denying or discontinuing medical assistance under this Section.

R9-22-1423. Social Security Number

A. Except as provided in subsection (B), an applicant shall furnish a SSN as provided in 42 CFR 435.910, May 29, 1986, and 42 CFR 435.920, May 29, 1986, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

B. An undocumented alien is not required to furnish a SSN.

R9-22-1424. State Residency

To be eligible under this Article, a person shall be a resident of Arizona as provided in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

R9-22-1425. Citizenship and Alien Status

A. An applicant shall be either:
1. A citizen of the United States, or
2. A qualified alien under A.R.S. § 36-2903.03.

B. The Department shall verify alien status by obtaining an applicant's alien registration documentation, or other proof of immigration registration, from the U.S. Immigration and Naturalization Service (INS), or by submitting an applicant's alien registration number and other related information to the INS for verification of alien status.

C. An alien who does not qualify under subsection (A) and who meets all other eligibility requirements, shall only receive emergency medical services as defined in R9-22-217.

R9-22-1426. Resources

A. Evaluation of resources. In determining eligibility for the 1931, 210, and Ribicoff groups described in R9-22-1406, the Department shall evaluate all resources under the provisions of this Section.

B. Included resources. The Department shall include the resources belonging to the persons listed in this subsection:
1. Members of the assistance unit defined in R9-22-1419,
2. The spouse of a nonparent caretaker relative if the nonparent caretaker relative is included in the assistance unit, and
3. Sponsor and sponsor's spouse of a person who is a qualified alien under A.R.S. § 36-2903.03.

C. Ownership and availability. The Department shall evaluate the availability of resources to the person listed in subsection (B) based on ownership.
1. Jointly-owned resources, with ownership records containing the words "and" or "and/or" between the owners' names, are available to each owner except if 1 of the owners refuses to sell. A consent to sale is not required if all owners are members of the assistance unit.
2. Jointly-owned resources, with ownership records containing the word "or" between the owners' names, are available in full to each owner.
3. The sole and separate property of 1 spouse is unavailable to the other spouse.

D. Unavailability. The Department shall consider the following resources unavailable:
1. Property subject to spendthrift restriction, which may include:
   a. Irrevocable trust funds; or
   b. Accounts established by the SSA, Veteran's Administration, or similar sources which mandate

that the funds in the account be used for the benefit of a person not residing with the assistance unit;

2. Resources being disputed in divorce proceedings or in probate matters; and
3. Real property located on a Native American reservation.

E. Resource exclusion. The Department shall exclude the following resources:

1. The primary residence of the person listed in subsection (B);
2. 1 burial plot for each person listed in subsection (B);
3. Household furnishings and personal items which are necessary for day-to-day living;
4. Up to $1500 of the value of 1 bona fide funeral agreement, for each person listed in subsection (B);
5. The value of 1 motor vehicle regularly used for transportation. If the assistance unit owns more than 1 vehicle, the exclusion is applied to the vehicle with the highest equity value, and the equity value of all remaining vehicles is counted toward the resource limit in subsection (B), subject to the limitations described in this Section;
6. A vehicle used to produce income;
7. The value of any vehicle in which the SSI recipient has an ownership interest;
8. The value of any vehicle used for medical treatment, employment, or transportation of a SSI disabled child, and which is excluded by SSI for that reason;
9. The person in subsection (B) owns real property that the Department shall count under this Section, and the person is making a good faith effort to dispose of the property, the Department shall count the resource subject to the following condition:
   a. The person shall sign an agreement to:
      i. Dispose of the property; and
      ii. Repay the Department as provided in R6-12-403(A)(7).
   b. The Department shall exclude the equity value of the property for a period of 6 months beginning with the date of the signed agreement under subsection (E)(9)(a).
   c. If the property is sold by the end of the 6-month period, the Department shall include any amount remaining after the Department is reimbursed as provided in R6-12-403(A)(7).
   d. If the property is not sold by the end of the 6-month period, the Department shall include the equity value of the property.
10. Funds set aside in an Individual Development Account defined in R6-12-404; and
11. Any other resource specifically excluded by federal law.

R9-22-1427. Determining Resource Eligibility

A. General. The Department shall follow the provisions of this Section to determine whether the person's countable resources exceed the resource standard in subsection(B).

B. Resource standard. The total equity value of all included resources shall not exceed $2000 per assistance unit.

C. Resource eligibility for coverage groups listed in R9-22-1406.

1. For the 1931 coverage group listed in R9-22-1406(B), the Department shall:
   a. Calculate the equity value of each countable resource of the assistance unit defined in R9-22-1419(B). If more than 1 owner is a member of the assistance unit, the equity value of the resource is counted only once;
   b. Add together the amounts in subsection (C)(1)(a);
   c. Compare the total amount calculated in subsection (C)(1)(b) to the resource standard provided in subsection (B); and
   d. Establish the assistance unit to be resource-eligible if the total of subsection (C)(1)(c) does not exceed the resource standard provided in subsection (B).
2. For coverage groups listed in R9-22-1406(G) and (H), the Department shall apply the following method to determine if the assistance unit is resource-eligible:
   a. Identify persons to be included in each assistance unit as specified in R9-22-1430(E)(2);
   b. Divide equally the equity value of each resource to be counted among the owners in the household;
   c. Divide equally each owner's share of the equity value of the countable resources by the number of persons for whom the owner is financially responsible applying the method under R9-22-1430(E)(2)(c);
   d. Add together the person's total allocated share of own resources and those of the financially responsible persons who are included in the assistance unit to determine the total amount of the person's resources;
   e. Determine the per-person share of the resource standard listed in subsection (B). The Department determines the per-person share of the $2000 resource standard by dividing the standard by the total number of persons in the applicant's assistance unit; and
   f. Compare the person's total income in subsection (C)(2)(d) to the per-person share of the standard as established in subsection (C)(2)(e). If the total does not exceed the person's standard, the applicant is resource- eligible.

R9-22-1428. Income

A. Evaluation of income. In determining eligibility, the Department shall evaluate all income under the provisions of this Section.

B. Types of income. The Department shall include the following:

1. Gross earned income, including in-kind income, before any deductions;
2. For self-employed applicants, the gross business receipts minus business expenses; and
3. Unearned income.

C. Persons whose income is counted. The Department shall include the income of the following persons:

1. Members of the assistance unit as defined in R9-22-1419,
2. The spouse of a nonparent caretaker relative if the nonparent caretaker relative is included in the assistance unit,
3. The sponsor and sponsor's spouse of a person who is a qualified alien under A.R.S. § 36-2903.03, and
4. For the coverage group listed in R9-22-1406(B):
   a. A spouse of a parent of a dependent child if the spouse is in the home but not in the assistance unit as provided in 45 CFR 233.20(a)(3)(xiv); and
   b. A parent of a minor parent if the parent is living with the minor parent but is not included in the assistance unit, as provided in 45 CFR 233.20(a)(3)(xviii).

D. Income exclusions. For the purposes of determining eligibility for this Article, the Department shall exclude the following income:
1. Agent Orange payments;
2. AmeriCorps Network Program income under subsection (D)(4);
3. Burial benefits dispersed solely for burial expenses;
4. Cash contributions from other agencies or organizations so long as the contributions are not intended to cover the following items:
   a. Food;
   b. Shelter, including only rent or mortgage payments;
   c. Utilities;
   d. Household supplies, including bedding, towels, laundry, cleaning, and paper supplies;
   e. Public transportation fares for personal use;
   f. Basic clothing or diapers; or
   g. Personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant;
5. Disaster assistance provided by the Federal Disaster Relief Act, disaster assistance organizations, or comparable assistance provided by state or local governments;
6. Educational grants or scholarships;
7. Energy assistance which is provided:
   a. Either in cash or in-kind by a government agency or municipal utility, or
   b. In-kind by a private nonprofit organization;
8. Earnings from high school on-the-job training programs;
9. Earned income of dependent children who are students enrolled and attending school at least half-time as defined by the institution;
10. Food stamp benefits;
11. Foster care maintenance payments intended for children who are not included in the assistance unit;
12. Funds set aside in an Individual Development Account as provided in R6-12-404;
13. Governmental rent and housing subsidies;
14. Income tax refunds, including any earned income tax credit;
15. Loans from a private applicant, a commercial, or educational institution;
16. Nonrecurring cash gifts which do not exceed $30 per applicant in any calendar quarter;
17. Radiation exposure compensation payments;
18. Reimbursement for work-related expenses which do not exceed the actual expense amount;
19. Reimbursement for JOBS Program training-related expenses;
20. Reparation and restitution payments under Section 1902(r) of the Social Security Act;
21. TANF or SSI cash assistance payment;
22. Vendor payment to a 3rd-party vendor to cover assistance unit expenses, provided the payment is made by an organization or a person who is not a member of the assistance unit;
23. Volunteers in Service to America (VISTA) income which does not exceed the state or federal minimum wage;
24. Vocational rehabilitation program payments made as reimbursement for training-related expenses, subsistence and maintenance allowances, and incentive payments which are not intended as wages;
25. Women, Infants, and Children (WIC) benefits; and
26. Any other income specifically excluded by applicable federal law.

E. Special income provision for child support. The Department shall:
1. Consider child support to be the income of the child for whom the support is intended, and
2. Count the child support income after deducting $50 per child if the child receives support:
   a. Directly from the absent parent,
   b. Through the Clerk of the Court, or
   c. Through the Court but assigned to DCSE.

F. Special income provision for nonrecurring lump sum income. The Department shall count a lump-sum payment as income in the month received.

G. Methods to determine projected monthly income.
1. The Department shall average income if income is received irregularly or regularly but from sources or in amounts which vary as follows:
   a. Add together income from a representative number of weeks or months; and
   b. Divide the resulting sum by the same number of weeks or months to determine the monthly amount.
2. The Department shall prorate income if income received is intended to cover a fixed period of time. The income received shall be averaged over the period of time the income is intended to cover to determine a monthly prorated amount.
3. The Department shall evaluate income under a fixed-term employment contract as follows:
   a. If contract income is received on a monthly or more frequent basis throughout all months of the contract, count the income in the month received;
   b. If contract income is received before or during the time the work is performed, but not as specified in subsection (3)(a), prorate the income over the number of months in the contract; or
   c. If payment is received only upon completion of the work:
      i. Divide the amount of the contract-payment by the number of months in the contract,
      ii. Apply the appropriate earned-income disregards specified in R9-22-1429 to determine net income for each month in the contract period,
      iii. Add together the net amount determined for each month in subsection (G)(3)(c)(ii) to determine total amount to count for the contract period; and
      iv. Count the total amount determined in subsection (G)(3)(c)(iii) as unearned lump-sum income under subsection (F).
4. The Department shall use the actual amount of income received in a month if the person:
   a. Receives or expects to receive less than a full month's income from a new source,
   b. Loses a source of income, or
   c. Is paid daily.
5. The Department shall use actual income received for a month in determining eligibility for prior quarter coverage as specified in R9-22-1432; or
6. The Department shall use the striker's prestrike monthly income if a person whose income shall be included is on strike.

H. Determining monthly income.

1. The Department shall calculate monthly income using the method described in subsection (G) for each assistance unit.
2. The projected income discussed in subsection (G) includes income which the assistance unit receives and expects to receive in a benefit month and shall be based on the Department's assessment of the assistance unit's current, past, and future circumstances.
3. The Department's calculation shall include all gross income from every source available to the assistance unit, except those excluded in subsection (D);
4. The Department shall convert income received more frequently than monthly into a monthly amount as follows:
   a. Multiply weekly amounts by 4.3,
   b. Multiply bi-weekly amounts by 2.15,
   c. Multiply semi-monthly amounts by 2.
5. The Department shall determine a new calculation of projected income:
   a. At each review, and
   b. If there is a change in countable income.

R9-22-1429. Earned Income Disregards

A. General. Except as provided in subsections (B)(2) and (C), the Department shall apply the earned income disregards in this Section to each employed person's gross earnings.

B. Disregards. The Department shall apply the method in this subsection to calculate the amount of the earned income:
   1. Subtract a $90 cost of employment (COE) allowance from the gross amount of earned income;
   2. For coverage groups listed in R9-22-1406(B), R9-22-1406(G), and R9-22-1406(H), subtract either a 30% of the remaining income or $30 plus 33% of the remaining income after applying the $90 COE as follows:
      a. Disregard 30% of the earned income for any month the person is employed; or
      b. If the 30% disregard results in income ineligibility of the assistance unit, the Department shall apply the $30 plus 33% income disregard for a period not to exceed 4 consecutive months beginning with the 1st month of employment; and
      c. The $30 plus 33% earned income disregard shall not apply again until after 12 months of ineligibility have elapsed; and
   3. Subtract an amount billed by the child care provider for the care of each dependent child or incapacitated adult member of the assistance unit, not to exceed:
      a. For a wage-earner employed full-time (86 hours a month):
         i. $200 for a child under age 2, and
         ii. $175 for the other dependents specified in subsection (B)(3); and
      b. For a wage-earner employed part-time (less than 86 hours a month):
         i. $100 for a child under age 2, and
         ii. $88 for the other dependents specified in subsection (B)(3).

C. Loss of disregards. The Department shall not apply the earned income disregards listed in subsections (B)(2), (B)(3), and (B)(4) if the person:
   1. Terminates or reduces employment within 30 days preceding a benefit month unless good cause is established as specified in R6-10-119(A); or
   2. Fails to report to the Department, a change in income within 10 days from the date the change becomes known. The change report to the Department shall be postmarked no later than the 10th day from the date the change becomes known. Good cause for failure to timely report a change or verification is limited to sickness, accident, or other family hardship.

R9-22-1430. Determining Income Eligibility

A. General. The Department shall evaluate income eligibility under this Section for any applicable eligibility coverage group listed in R9-22-1406.

B. Income eligibility standard.
   1. For the coverage groups listed in R9-22-1406(B), R9-22-1406(G), and R9-22-1406(H), the income eligibility standard is 36% of the need standard specified in subsection (C) for the number of persons in the assistance unit.
   2. For the coverage groups listed in R9-22-1406(I) and R9-22-1406(J), the income eligibility standard is the percentage of the FPL as follows:
      a. 140% of the FPL for a pregnant woman or a child under the age of 1,
      b. 133% of the FPL for a child age 1 through 5, and
      c. 100% of the FPL for a child born on or after 10/1/83 who is age 6 and over.
   3. For the coverage group listed in R9-22-1406(F), the standard is 185% of the FPL for the number of persons in the assistance unit.

C. Need standard. The need standard is 100% of the 1992 FPL, adjusted for a shelter cost factor as provided in subsections (C)(1) and (C)(2) for the number of persons in the assistance unit. The shelter cost factor reduces the federal poverty level by 37% if the person does not pay or is not obligated to pay, shelter costs for the place of residence.
   1. The Department shall use 100% of the need standard if:
      a. The assistance unit pays, or is obligated to pay, all or part of the shelter costs for the place in which assistance unit members reside. Shelter costs include rent, mortgage, or taxes;
      b. The assistance unit members reside in subsidized public housing;
      c. A member of the assistance unit works in exchange for rent; or
      d. A nonparent relative whom the Department excludes from the assistance grant:
         i. Charges the dependent child rent, or
         ii. Uses a portion of the dependent child's cash assistance grant to pay household expenses.
   2. If the assistance unit does not meet the requirements of subsection (C)(1), the Department shall determine the assistance unit's need standard based on 63% of the 1992 100% FPL.

D. Determining income eligibility.
   1. The Department shall find the assistance unit income-eligible if the assistance unit's income meets the appropriate income standard specified in subsection (B).
   2. The Department shall establish income eligibility as follows:
      a. Identify the assistance unit under R9-22-1419 for the appropriate coverage group.
      b. Determine whose income is to be counted under R9-22-1428(C).
      c. Determine what income is to be counted under R9-22-1428.
      d. Determine the amount of income to be counted under subsection (E)(2), R9-22-1428, and R9-22-1429.

e. Compare the amount in subsection (D)(2)(d) to the appropriate income standard in subsection (B).
f. Determine the assistance unit income eligibility if the income does not exceed the appropriate income standard specified in subsection (B).

E. Method to determine income eligibility. The Department shall apply the following method to establish the requirements of (D)(2)(d), (e), and (f):
1. For coverage group listed in R9-22-1406(B), the Department shall determine whether the assistance unit in R9-22-1419(B) meets the following 3 income tests:
a. To determine whether the assistance unit meets 185% of the need standard defined in subsection (C), the Department shall:
i. Determine the assistance unit's gross income specified in subsection (D)(2).
ii. Deduct the income disregards described in subsection (E)(1)(d).
iii. Compare the resulting amount of income to the 185% standard. If the amount does not exceed the standard, the assistance unit meets this test.
b. If the assistance unit meets the 185% test under subsection (E)(1)(a), the Department shall determine whether the assistance unit meets the need test defined in subsection (C) as follows:
i. Use the same amount of gross income in subsection (E)(1)(a)(i);
ii. Deduct the income disregards described in subsection (E)(1)(d) and in R9-22-1429;
iii. Compare the resulting amount of income to the need standard in subsection (C). If the amount is less than the standard, the assistance unit meets this test.
c. If the assistance unit meets the need test in subsection (E)(1)(b), the Department shall compare the amount of income in subsection (E)(1)(b)(iii) to the payment standard in subsection (B)(1). If the amount is less than the standard, the assistance unit qualifies and is income eligible.
d. For the purpose of subsections (E)(1)(a) and (E)(1)(b), the Department shall disregard the following income of children who are members of the assistance unit defined in R9-22-1419:
i. All earned income from participation in the JTPA for up to 6 months per calendar year; and
ii. All unearned income received from participation in JTPA.
2. For coverage groups listed in R9-22-1406(G), R9-22-1406(H), R9-22-1406(I), and R9-22-1406(J), the Department shall determine income eligibility separately for each applicant as follows:
a. Establish a separate assistance unit for each applicant as provided in R9-22-1419(E);
b. After applying all applicable income disregards, divide equally the income of financially responsible relatives specified in subsection (E)(2)(c) among the owner of the income and other persons in the household for whom the owner is financially responsible. The resulting amount is the person's allocated income.
c. The following persons are financially responsible:
i. A child is financially responsible for the child,.
ii. A parent is financially responsible for the parent and the parent's dependent children, and
iii. A married person is financially responsible for the person and the person's spouse.
d. Determine the per-person share of the appropriate income standard as provided in subsection (B). The Department shall determine the per-person share of the income standard by dividing the income standard by the total number of persons in the applicant's assistance unit. For example:
i. A child and the child's parent is a household of 2. The child's share of the appropriate income standard is 1/2 of 2.
ii. A pregnant minor child, the unborn child, the minor child's 2 parents and the minor child's spouse is a household of 5. The pregnant minor child's share of the appropriate income standard is 2/5. The Department shall count the unborn child of the pregnant minor child in determining the pregnant minor child's per-person share of the income standard.
e. Add together the applicant's share of the applicant's own income with any income allocated to the applicant under subsection (E)(2)(b), and compare the applicant's total income to the per-person share of the standard under subsection (E)(2)(d). If the applicant's income is equal to or less than the income standard under (E)(2)(d), the applicant qualifies and is income eligible:
3. Income eligibility or coverage groups listed in R9-22-1406(F) shall be calculated as follows:
a. Divide the total gross earned income for the preceding 6-month period of TMA by 6 to determine average gross earned income for the period;
b. Subtract the monthly child care amount billed by the child care provider from the average gross earned income. To be allowed as a disregard under R9-22-1429(D), the child care shall be necessary for the employment of the caretaker relative.;
c. The resulting total may not exceed 185% of FPL.

R9-22-1431. Effective Date of Eligibility
Except as provided in R9-22-1432 and R9-22-1433, the effective date of eligibility shall be the 1st day of the month of application if the applicant is eligible that month, or the first eligible month following the application month.

R9-22-1432. Prior Quarter Eligibility
A. The Department shall evaluate the applicant's eligibility for 1 or more months during the 3-month period before the 1st day of the month of application if the applicant:
1. Received a medical service at any time during the 3-month period prior to the application month; and
2. Would have been eligible under this Article, if the applicant had filed an application at the time of receiving services.
B. The Department shall determine the applicant's eligibility under any eligibility coverage group listed in R9-22-1406(A), R9-22-1406(G), R9-22-1406(H), R9-22-1406(I), or R9-22-1406(J) for 1, 2, or all 3 of the months before the 1st day of the month of application.

R9-22-1433. Deemed Newborn Eligibility
A child born to a categorically eligible mother is automatically eligible for AHCCCS medical assistance for a period not to exceed

12 months beginning with the child's date of birth and ending with the last day of the month in which the child turns age 1, if the child continuously lives with the mother in the State of Arizona.

R9-22-1434. Extended Medical Assistance Coverage for A Pregnant Woman

A. Except as provided in subsection (C), a pregnant woman who applies for and is determined categorically eligible for medical assistance during the pregnancy, remains eligible throughout the 60-day postpartum period.

B. The postpartum period begins the day the pregnancy terminates, and ends the last day of the month in which the 60th day falls.

C. Postpartum coverage will not be provided if the woman:
1. Voluntarily withdraws from the Medical Assistance program,
2. Moves out-of-state, or
3. Is incarcerated.

D. Extended coverage under this Section applies only if the person does not receive medical assistance under another categorical coverage group provided in 9 A.A.C. 22 or 9 A.A.C. 28.

R9-22-1435. Family Planning Services Extension Program

A. Except as specified in this Section, a person may receive family planning services as provided in A.R.S. § 36-2907.04.

B. The Administration shall deny or terminate family planning services under this Section if any 1 of the following occurs:
1. Voluntary withdrawal,
2. Loss of contact,
3. Failure to cooperate,
4. Failure to provide information,
5. Incarceration,
6. Move out-of-state,
7. Sterility, or
8. Death.

R9-22-1436. Eligibility Appeals

A. Adverse actions. A person may appeal and request a hearing concerning any of the following adverse actions:
1. Complete or partial denial of eligibility;
2. Suspension, termination, or reduction of medical assistance; or
3. Delay in the eligibility determination beyond 45 days from the application date.

B. Notice of Action. The Department shall personally deliver or mail, by regular mail, a Notice of Action to the person affected by the action. For the purpose of this Section, the date of the Notice of Action shall be the date of personal delivery to the applicant or the postmark date, if mailed.

C. Automatic adjustments. Applicants and recipients are not entitled to a hearing to challenge changes made automatically as a result of changes in federal or state law, unless the Department has incorrectly applied the law to the person seeking the hearing.

D. Hearings to the Department of Economic Security. Applicants and recipients may request a hearing from the Department. The Department shall conduct the hearing in accordance with the Department's appeal procedures contained in R6-12-1002, R6-12-1003, and R6-12-1005 through R6-12-1015. For purposes of this Section, any references in the Department's rules to the word "benefits" shall refer to medical assistance, any reference to the cash assistance program shall refer to the medical assistance program, and references to overpayments are not applicable.

E. Stay of adverse action pending appeal and exceptions.
1. If an appellant files a request for appeal within 10 calendar days after the date of the Notice of Action, the Department shall not impose the adverse action and shall continue medical assistance at the current level unless:
   a. The appellant specifically waives continuation of current benefits, or
   b. The appeal results from a change in federal or state law which mandates an automatic adjustment for all classes of recipients and does not involve a misapplication of the law;
2. The Department shall not impose the adverse action until receipt of an official written decision from the hearing officer except in the following circumstances:
   a. At the hearing and on the record, the hearing officer finds that:
      i. The sole issue involves application of law,
      ii. The Department properly applied the law, and
      iii. The Department determined the correct level of assistance for the appellant;
   b. A change in eligibility occurs for a reason other than the issue on appeal, and the assistance unit receives and fails to timely appeal a Notice of Action concerning the change;
   c. Federal or state law mandates an automatic adjustment for classes of recipients;
   d. The appellant withdraws the request for hearing; or
   e. The appellant fails to appear for a scheduled hearing without prior notice to the Department's Office of Appeals, and the hearing officer does not rule in favor of the appellant based upon the record.
3. An appellant whose medical assistance has been continued may be financially liable for all medical assistance received during a period of ineligibility if the Department upholds a discontinuance decision.
4. If the appellant files a request for appeal more than 10 days after, but within 20 days of, the date of the Notice of Action, the Department may impose the adverse action while the appeal is pending.

F. Retroactive eligibility. If the Department's Office of Appeals hearing decision upholds the appellant, the decision is retroactive to the effective date contained in the Notice of Action.

F. Appeal to Appeals Board.
1. An appellant may appeal the hearing decision to the Department's Appeals Board under R6-12-1014.
2. The Appeals Board shall issue a final written decision to the appellant under R6-12-1015. The Appeals Board's final decision shall identify the appellant's right to appeal to the Administration.

G. Review of the Appeals Board decision.
1. The appellant may request a review of the Appeals Board's final decision by filing an appeal with the Administration under 9 A.A.C. 22, Article 8 within 15 days of the postmark date of the Appeals Board's decision.
2. Unless the appellant requests a de novo hearing, the appeal to the Administration shall consist of a review of the record of the Department's evidentiary hearing to determine whether substantial evidence in the record supports the decision. In the event the appellant requests a de novo hearing, the Administration shall conduct the hearing under 9 A.A.C. 22, Article 8.

ARTICLE 15. SSI MAO ELIGIBILITY

R9-22-1501. SSI Medical Assistance Only (MAO) Coverage Groups

A. Using the eligibility criteria and requirements in this Article, the Administration shall determine eligibility for services described in 9 A.A.C. 22, Article 2 and 9 A.A.C. 22, Article 12, for applicants in the following eligibility groups:

1. A SSI noncash person who is aged, blind, or disabled, under 42 CFR 435.210, August 18, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. A disabled child (DC), under 42 U.S.C. 1396a(a)(10)(A)(i)(II), July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. A disabled child is a child who:
   a. Was receiving SSI cash benefits as a disabled child on August 22, 1996;
   b. Lost SSI cash benefits effective July 1, 1997, or later, due to a disability determination under Section 211(d)(2)(B) of Subtitle B of P.L. 104-193, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Continues to meet the disability requirements for a child which were in effect on August 21, 1996.
3. A disabled adult child (DAC), as specified in 42 U.S.C. 1383c(c), who:
   a. Was determined disabled by the Social Security Administration before attaining the age of 22 years;
   b. Became entitled to or received an increase in child's insurance benefits under Title II of the Social Security Act on the basis of blindness or disability;
   c. Was terminated from SSI cash benefits due to entitlement to or an increase in Title II of the Social Security Act (DAC) income;
   d. Has income equal to or below 100% of the FBR if the Title II (DAC) income is excluded from the calculation of eligibility; and
   e. Is 18 years of age or older.
4. A disabled widow or widower (DWW), as specified in 42 U.S.C. 1383c(d) who:
   a. Is blind or disabled;
   b. Is ineligible for Medicare Part A benefits;
   c. Received SSI cash benefits the month before Title II of the Social Security Act (DWW) benefit payments began;
   d. Would have income equal to or below 100% of the FBR since losing the SSI cash benefits if the amount of the Title II of the Social Security Act benefit (DWW) income was excluded from the calculation of eligibility; and
   e. Would continually meet all conditions of eligibility specified in this Article after losing SSI cash benefits.
5. A person, as specified in 42 CFR 435.135 who:
   a. Is aged, blind, or disabled;
   b. Receives benefits under Title II of the Social Security Act;
   c. Received SSI cash benefits in the past;
   d. Received SSI cash benefits and Title II of the Social Security Act benefits concurrently for at least 1 month anytime after April 1977;
   e. Became ineligible for SSI cash benefits while receiving SSI and Title II of the Social Security Act concurrently; and
   f. Would have income equal to or below 100% of the FBR if the Title II of the Social Security Act COLA increases received on or after losing SSI Cash benefits were excluded from the calculation of eligibility.
6. A state funded nonqualified alien, as specified in A.R.S. § 36-2903.03.C who:
   a. Is aged, blind, or disabled;
   b. Received SSI cash or AHCCCS medical benefits under an SSI MAO coverage group listed in subsections (A)(1) through (A)(5) on or before August 21, 1996; and
   c. Was residing in the United States under color of law on or before August 21, 1996.

B. Under the Federal Emergency Services Program (FESP), a person who meets the conditions of eligibility for SSI noncash, in subsection (A)(1) but who does not meet the alien status requirements specified in R9-22-1504(A) or (B), shall be entitled to services described at R9-22-217.

R9-22-1502. Eligibility Determination Process

A. Applications for SSI MAO.

1. The Administration shall provide a person the opportunity to apply for SSI MAO.
2. An applicant may be accompanied, assisted or represented by another person in the application process.
3. To apply for SSI MAO, a person shall submit a written application to the Administration's eligibility office.
   a. The application shall contain an applicant's name and address.
   b. The application may be submitted by the applicant or representative.
   c. The Part I Application shall be signed by an applicant requesting SSI MAO benefits or by a representative.
   d. An application shall be witnessed and signed by a 3rd-party if an applicant signs an application with a mark.
   e. The application date is the date an application is received at any Administration office.
4. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond the following timeframes when information necessary to make the determination has been provided or obtained:
   a. 90 days for an applicant applying on the basis of disability; or
   b. 45 days for all other applicants.
5. The applicant or representative who filed an application may withdraw the application either orally or in writing at the office where the applicant or representative filed the application. An applicant who withdraws an application shall receive a denial notice under subsection (I).

B. Determination of eligibility for an applicant terminated from SSI cash program.

1. Continuation of AHCCCS medical assistance. The Administration shall continue AHCCCS medical assistance for an applicant terminated from SSI cash program

until a redetermination of eligibility under subsection (B)(2) is completed under 42 CFR 435.916.

2. Coverage group screening. The Administration shall screen for eligibility under any coverage group specified in A.R.S. §§ 36-2901.4(b) and 36-2934.
   a. If an applicant has filed an application for ALTCS coverage, the Administration shall determine eligibility under 9 A.A.C. 28, Article 4.
   b. If an applicant is aged, blind, or disabled, but not in need of long-term care services, the Administration shall determine eligibility under this Article.
   c. If an applicant is a child, is pregnant, or the caretaker relative of a deprived child, the Administration shall refer the case to DES for an eligibility decision under 9 A.A.C. 22, Article 14.
3. Eligibility decision.
   a. If the applicant is eligible, the Administration shall send a notice informing the applicant that AHCCCS medical assistance will continue.
   b. If the applicant is ineligible, the Administration shall send a notice proposing discontinuing AHCCCS medical coverage.
4. County referral. If an applicant is found ineligible under subsection (B)(2), the Administration shall refer the person to a county AHCCCS eligibility office to apply for medical assistance under 9 A.A.C. 22, Article 16. The referral shall include:
   a. Referral instructions on the notice of proposed termination of categorical eligibility;
   b. Information about the county AHCCCS eligibility determination process, including location of county eligibility offices, income and resource limits, other conditions of eligibility, and verification requirements; and
   c. A postcard, which if completed and returned to the county eligibility office under R9-22-1604, shall initiate an MI/MN application.

C. Conditions of SSI MAO Eligibility. An applicant shall only be approved for SSI MAO under this Article when the following conditions of eligibility are met:
1. Coverage group under R9-22-1501;
2. State residency under R9-22-1503;
3. Citizenship and alien status under R9-22-1504;
4. SSN under R9-22-1505;
5. Resources under R9-22-1506;
6. Income under R9-22-1507;
7. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any 1st-and 3rd-parties and shall cooperate by:
   a. Establishing paternity and obtaining medical support and payments unless an applicant establishes good cause for not cooperating; and
   b. Identifying and providing information to assist the Administration in pursuing 1st-and 3rd-parties who may be liable to pay for care and services unless an applicant establishes good cause for not cooperating; and
8. Application for potential benefits by requiring an applicant to take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which an applicant may be entitled, unless the person establishes good cause for not doing so.

D. Inmate of a public institution. An inmate of a public institution is not eligible for SSI MAO if federal financial participation (FFP) is not available.

E. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following or authorize the Administration to obtain verification of the following:
1. Coverage groups as specified in R9-22-1501,
2. State residency as specified in R9-22-1503,
3. Citizenship and alien status as specified in R9-22-1504,
4. SSN as specified in R9-22-1505,
5. Resources as specified in R9-22-1506,
6. Income as specified in R9-22-1507,
7. 1st-and 3rd-party liability and recovery as specified in subsection (C)(7),
8. Applying for potential benefits as specified in subsection (C)(8), and
9. Other individual circumstances necessary to determine an applicant's eligibility.

F. Documentation of the eligibility decision. The SSI MAO eligibility interviewer shall include information in a person's case record to support any decision on a person's application.

G. Eligibility effective date. Eligibility shall be effective the 1st day of the month all eligibility requirements are met, but no earlier than the prior quarter period.

H. Prior quarter.
1. Prior quarter period. Eligibility for the prior quarter shall be no earlier than 3-months prior to the month of application.
2. Prior quarter eligibility.
   a. Eligibility for prior quarter acute care coverage is determined for each month of a prior quarter period on a month-by-month basis and shall be for 1, 2, or 3-months of the prior quarter period.
   b. A person shall meet all eligibility criteria related to a coverage group listed in R9-22-1501 for each approved prior quarter month.

I. Notice. The Administration shall send the person a written notice of the decision regarding the application. This notice shall include a statement of the intended action, explanation of a person's hearing rights as specified in 9 A.A.C. 22, Article 8, and:
1. If approved, the notice shall contain:
   a. The effective date of eligibility; and
   b. If approved under FESP, the emergency services certification end date.
2. If denied, the notice shall contain:
   a. The effective date of the denial;
   b. A statement detailing the reason for the denial, including specific financial calculations and the financial eligibility standard if applicable; and
   c. The legal authority supporting the decision.

J. Confidentiality. The agency shall maintain the confidentiality of the person's records and shall not disclose the person's financial, medical, or other privacy interests except as specified in R9-22-512.

R9-22-1503. State Residency

As a condition of eligibility, a person shall be a resident of Arizona under 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

R9-22-1504. Citizenship and Qualified Alien Status

A. Requirements for coverage groups listed in R9-22-1501(A)(1) through (A)(5). As a condition of eligibility, an applicant applying for or a person receiving assistance shall be either:
   1. A citizen of the United States under A.R.S. § 36-2903.03; or
   2. A qualified alien as specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent that A.R.S. § 36-2903.03 is consistent with federal law.

B. Requirement for the coverage group listed in R9-22-1501(A)(6). As a condition of eligibility, an applicant applying for or a person receiving assistance shall be:
   1. A nonqualified alien who received AHCCCS benefits under SSI cash or SSI MAO, except for FESP, on August 21, 1996; and
   2. Coverage under this program is subject to the appropriation of funds by the Arizona Legislature. A person who was residing in the United States under color of law on or before August 21, 1996, as specified in A.R.S. § 36-2903.03.

C. FESP. The Administration shall determine an applicant's eligibility under FESP if the applicant does not meet the citizenship or qualified alien status requirements in subsections (A) and (B).

R9-22-1505. Social Security Enumeration

A. Requirement for the coverage groups listed in R9-22-1501(A)(1) through (A)(5). As a condition of eligibility an applicant shall furnish a SSN, as specified in 42 CFR 435.910 and 435.920.

B. Exception for coverage under R9-22-1501(B). An undocumented a person who is applying for or receiving assistance is not required to apply for or furnish a SSN.

R9-22-1506. Resource Criteria for SSI MAO Eligibility

A. Resource eligibility. Except as provided in subsection (B), resource eligibility is determined using the resource criteria in 42 U.S.C. 1382(a)(2)(B), August 5, 1997, incorporated by reference and on file with the Administration and the Secretary of State. The incorporation by reference contains no future editions or amendments.

B. Exceptions. The value of the following resources is excluded from eligibility determination:
   1. Household goods and personal effects;
   2. Burial Insurance;
   3. Assets that an applicant has irrevocably assigned to fund the expenses of a burial;
   4. The value of life insurance if the face value does not exceed $1,500 total per insured applicant and the policy has not been assigned to fund a burial plan or declaratively designated as a burial fund;
   5. The equity value up to $1,500 of an asset to be used as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement, and if an applicant remains continuously eligible, all appreciation in the value of such assets; and
   6. The value of oil, mineral, and timber rights.

C. Resource limits. A person is not eligible if countable resources owned by the person exceed $2,000 for a person or $3,000 for a couple under 42 U.S.C. 1382(a)(3)(A) and (B).

R9-22-1507. Income Criteria for Eligibility

A. Countable income for a person is determined as follows:
   1. General income eligibility. Except as specified in subsections (A)(2) and (A)(3), income eligibility is determined using the methodology in 42 U.S.C. 1382(a), August 5, 1997, and 42 U.S.C. 1382a, August 22, 1996, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.
   2. Exceptions which apply to all coverage groups.
      a. In-kind support and maintenance is excluded. In-kind support and maintenance is explained at 42 U.S.C. 1382a(a)(2)(A), August 22, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
      b. For a person living with a spouse, the computation rules for an eligible couple are followed for the net income calculation, even if the spouse is not eligible for or applying for SSI or SSI MAO.
      c. In determining the net income of a couple living with a child, a child allocation is allowed as a deduction from the combined net income of the couple for each child regardless of whether the child is ineligible or eligible. For the purposes of this Section, a child means a person who is unmarried, natural or adopted, under age 18 or under age 22 if a full-time student. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments, using the methodology described in 20 CFR 416.1163(b)(1) and (2), May 4, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
      d. In determining net income of a person who is not living with a spouse, but living with a child, a deduction from the parent's net income using the methodology described in 20 CFR 416.1163(b)(1) and (2), is allowed for each child regardless of whether the child is ineligible or eligible. Each child's allocation deduction is reduced by that child's income, including public income maintenance payments.
      e. In determining the income deemed available to an applicant who is a child, from an ineligible parent or parents, an allocation for each eligible or ineligible child of the parent is allowed as a deduction from the parent's income using the methodology described in 20 CFR 416.1165(b) and each child's allocation is reduced by that child's income, including public income maintenance payments. The methodology in 20 CFR 416.1165(b), January 8, 1997, is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   3. Exceptions which apply to specific coverage groups.
      a. For a person in the DAC coverage group, defined by R9-22-1501(A)(3), the applicant's Title II of the Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(c), March 29, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
      b. For a person in the DWW coverage group, defined by R9-22-1501(A)(4), the applicant's Title II of the

Social Security Act benefits are disregarded in determining income eligibility under 42 U.S.C. 1383c(b) and (d), March 29, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

c. For an applicant in the coverage group defined by R9-22-1501(A)(5), the portion of the applicant's Title II of the Social Security Act benefits attributed to cost-of-living adjustments received by the applicant since the effective date of SSI ineligibility is disregarded in determining income eligibility under 42 CFR 435.135, May 12, 1986, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. As a condition of eligibility for all coverage groups, countable income shall be equal to or less than 100% of the SSI FBR, adjusted annually, for a person or a married couple.

R9-22-1508. Changes and Redeterminations

A. Reporting and verifying changes.

1. Under 42 CFR 435.916, a member shall report to the SSI MAO unit the following changes for a member, a member's spouse, and a member's dependent children:
   a. A change of address;
   b. An admission to a penal institution;
   c. A change in the household's members;
   d. A change in income;
   e. A change in resources;
   f. A determination of eligibility for other benefits;
   g. A death of any household member;
   h. A change in marital status;
   i. A change in school attendance;
   j. A change in Arizona state residency;
   k. A change in U.S. citizenship or alien status;
   l. Receipt of a SSN under R9-22-1505;
   m. A change in trust assets, income, and disbursements;
   n. A change in 1st-or 3rd-party liability which may contribute to the payment of all or a portion of the person 's medical costs; and
   o. Any other change that may affect the applicant's eligibility.
2. A person may report a change either orally or in writing and shall include the:
   a. Name of the affected applicant;
   b. Change;
   c. Date the change occurred;
   d. Name of the person reporting the change; and
   e. Social Security or case number of the household member, if known.
3. A person shall provide verification of changes upon request of AHCCCS.
4. A person shall report anticipated changes in eligibility as soon as the future event becomes known.
5. A person shall report unanticipated events within 10 days of the date the change occurred.

B. Processing of changes and redeterminations. If a person receives benefits under R9-22-1501(A), a person's eligibility shall be redetermined at least once every 12 months or more frequently when changes occur, under 42 CFR 435.916.

C. Actions that may result from a redetermination or change. The processing of a redetermination or change shall result in 1 of the following findings:

1. No change in eligibility;
2. Discontinuance of eligibility if any condition of eligibility is no longer met;
3. Suspension of eligibility if any condition of eligibility is temporarily not met; or
4. A change in the program under which a person receives assistance.

D. Notices.

1. Contents of notice. The Administration shall issue a notice whenever it takes an action regarding a person's eligibility. A notice shall contain the following information:
   a. A statement of the action that is being taken;
   b. The effective date of the action;
   c. The reason for the intended action;
   d. The actual amounts used in the eligibility determination and specify the amount by which a person exceeded standards if eligibility is being discontinued because either a person's resources exceed the resource limit described at R9-22-1506 or the person's income exceeds the income limit described at R9-22-1507;
   e. The specific law or rule that supports the action proposed by the Administration, or a change in federal or state law that requires an action;
   f. An explanation of an applicant's right to request a fair hearing; and
   g. If a discontinuance or suspension, an explanation of the date by which a fair hearing shall be requested so that eligibility will be continued.
2. Advance notice of changes in eligibility. Advance notice means a proposed notice of action that is issued to the person at least 10 days before the effective date of the proposed action under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever adverse action is taken to discontinue or suspend eligibility if an eligible applicant no longer meets a condition of eligibility.
3. Exceptions from advance notice. Under 42 CFR 431.213, notice shall be issued to the person to discontinue eligibility no later than the effective date of action if:
   a. A person provides a clear written statement, signed by that person, that services are no longer wanted.
   b. A person provides information that requires termination of eligibility and a person signs a written statement waiving advance notice;
   c. A person cannot be located and mail sent to the person's last known address has been returned as undeliverable;
   d. A person has been admitted to a penal institution where a person is ineligible for benefits;
   e. A person has been approved for Medicaid in another state; or
   f. The Administration receives information confirming the death of a person.

ARTICLE 16. STATE-ONLY ELIGIBILITY

R9-22-1601. Who May Apply for MI/MN Benefits

A. Right to apply. The county eligibility staff shall provide the unrestricted opportunity for any person to apply for MI/MN benefits.

B. Application by the head-of-household. The head-of-household shall apply on behalf of all members of the household.

C. Application by a designated representative. A designated representative may act on behalf of the head-of-household to apply for MI/MN if no household member is able to act as head-of-household.
1. The designated representative shall have all rights and responsibilities and fulfill all the requirements as specified for the head-of-household in this Article.
2. A designated representative shall be 1 of the following:
a. A person appointed by a tribal court or through protective proceedings as defined in A.R.S. § Title 14, Chapter 5, or the applicant's guardian, conservator, or executor;
b. A representative authorized in writing by the head-of-household;
c. Any adult household member who would have been a household member if not for categorical status;
d. A person who has knowledge of the family circumstances if the head-of-household is deceased or cannot designate a representative due to incapacity and there is no other available designated representative as defined in this Section.
i. Incapacity shall be verified by written documentation signed by a licensed physician, physician assistant, nurse practitioner, or a registered nurse under the direction of a licensed physician.
ii. An applicant who meets the definition of designated representative under this subsection but who is incapacitated under subsection (C)(2)(d)(i) is not an available designated representative.
e. A person who applies on an applicant's behalf as permitted in subsections (E) and (F).

D. Applications by dependent children. A dependent child may be head-of-household and apply for MI/MN only coverage if the dependent child:
1. Is pregnant or is a parent residing with the dependent child's own child, and
2. Does not live with a person who is legally responsible for that child's support.

E. Applications for dependent children. Except as permitted in subsection (D), if a dependent child is a member of a household that does not include a parent or specified relative, only 1 of the following may apply for MI/MN coverage on the child's behalf:
1. The dependent child's legal guardian;
2. A representative of an authorized agency appointed through court proceedings established by A.R.S. § 8-538, et seq.; or
3. A foster parent duly appointed by:
a. The Superior Court of the State of Arizona,
b. The Department of Economic Security,
c. A Native American Tribal Court, or
d. A Native American Tribal Agency.

F. Applications by court-appointed representatives. If a court appoints a guardian, conservator, or executor for a person, the application shall be completed by the court's appointee.

G. Verification of representative's qualifications. If a designated representative or a legal representative for a dependent child applies on behalf of the head-of-household or a dependent child, the county eligibility staff shall verify that the representative meets 1 of the conditions specified in subsection (C)(2).

R9-22-1602. Application for MI/MN Benefits

A. Distribution of application forms. Any person may request an application form from the county eligibility staff either in-person, through the mail, or by telephone.
1. The county eligibility staff shall ask each person who inquires either in-person or by telephone about the AHCCCS program, the following question: "Do you want to apply for AHCCCS?"
2. If the response is yes, the county eligibility staff shall:
a. Mail the Part I Application within 3 working days of the receipt of:
i. A telephone request, or
ii. A mail request, or
b. If the request is in-person, the county eligibility staff shall immediately provide the person with a Part I Application.

B. Initiation of the application process. The head-of-household may initiate the application by submitting a completed Part I Application to a county eligibility staff within the county of the head-of-household's physical residence. A completed application shall contain the name, address, signature or mark of the applicant, and the date.

C. Acceptance of the application. The county eligibility staff shall date stamp or manually date the application. For applications that are not priority applications under R9-22-1603, the received date is the application date.

D. Confirmation of receipt. The county eligibility staff shall return a copy of the receipt, and dated Part I Application to the head-of-household:
1. Immediately, for an application submitted in-person; or
2. Within 3 days of receipt of the Part I Application, for applications received by mail. The confirmation of receipt may be provided with the appointment notice under subsection (E).

E. Scheduling the interview. A county eligibility staff shall schedule a face-to-face interview with the head-of-household, upon receipt of a Part I Application.
1. If the application is submitted in-person, the county eligibility staff shall either immediately conduct the interview or schedule a mutually agreeable appointment and provide the head-of-household with written confirmation of the appointment.
2. If the completed Part I Application is received by mail, the county eligibility staff shall schedule an interview, or attempt to contact the head-of-household, to schedule an interview within 3 working days. The head-of-household may change the interview appointment 1 time if the request to change is made before the originally scheduled interview. The county eligibility staff shall then change the interview to a mutually agreeable time.
3. If the county eligibility staff does not receive acknowledgment of a scheduled interview from the head-of-household, the county eligibility staff shall make at least 1 additional attempt to notify the head-of-household of the scheduled appointment.

F. Priority for a pregnant woman. The county eligibility staff shall give priority to the processing of an application for a pregnant woman.

R9-22-1603. Priority Applications for MI/MN Eligibility

A. Conditions for a priority application. A provider of medical services may initiate a priority MI/MN application for a patient and the patient's household if the patient is not an AHCCCS member but is potentially MI/MN, ELIC, or SESP eligible, and

1. Is receiving medical care, or received medical care within the previous 2 days,
2. Is hospitalized, or
3. Has been hospitalized during the previous 2 days.

B. Verification of AHCCCS coverage. If a patient's AHCCCS eligibility is not known, the provider shall contact the Administration to determine whether the patient is eligible.

C. Initiation of a priority application. To initiate a priority application, the provider shall contact the county eligibility staff in the patient's county of residence, and provide the following information.
1. The provider's name, address, and telephone number;
2. Patient's name and physical and mailing address;
3. Patient's telephone number and Social Security number if those numbers are known;
4. For a patient who is a dependent child, the parent's or responsible adult's name, address, and telephone number and Social Security number if available;
5. Patient's current physical location;
6. Name and address of the facility where treatment is, was, or will be provided;
7. Date and time of admission or initiation of treatment;
8. Expected duration of the medical treatment requiring hospitalization and discharge date and time, if known;
9. Description in layman's terms of the diagnosis, accident, or illness that resulted in the hospitalization;
10. 1st-and 3rd-party liability information, if known;
11. Date and time the provider contacts the county eligibility staff.

D. Processing of a priority application.
1. The date of a priority application is the day the provider contacts the county eligibility staff in the patient's county of residence.
2. Upon receipt of a priority application the county eligibility staff shall schedule a face-to-face interview.
   a. If the county eligibility staff is able to meet in-person with the head-of-household, the county eligibility staff shall conduct the interview or schedule a mutually agreeable appointment time and provide the head-of-household with written confirmation of the appointment time.
   b. If the county eligibility staff is unable to meet in-person with the head-of-household, the county eligibility staff shall, within 3 working days following the date of a priority application, schedule an interview or attempt to contact the head-of-household to schedule an interview. The head-of-household may change the appointment 1 time if the request to change is made before the originally scheduled interview. The county eligibility staff shall then change the interview to a mutually agreeable time. If the county does not receive acknowledgment of the scheduled interview from the head-of-household, the county eligibility staff shall make at least 1 additional attempt to notify the head-of-household of the scheduled appointment.
3. The county eligibility staff shall determine eligibility under this Article.

E. Head-of-household's responsibilities. The head-of-household shall complete the application process under R9-22-1605.

F. Provider responsibility. If the county eligibility staff notifies the provider that the patient's eligibility may be dependent on incurred medical expenses, the provider shall make reasonable efforts to provide the county eligibility staff with timely information regarding amounts of billed charges and 1st- and 3rd-party liability for those changes.

R9-22-1604. MI/MN Applications for Applicants Facing a Loss of Categorically Eligible Status Due to Termination of SSI Benefits

A. Postcard request for MI/MN coverage. A person who receives an AHCCCS categorical termination notice and a pre-printed postcard under R9-22-1502 may initiate the application process for MI/MN eligibility by mailing or submitting the postcard to the county of residence eligibility staff within 7 days following the issuance date of the postcard. The date of the postmark, or if there is no postmark, the date of receipt by the county eligibility staff is the application date. The county eligibility staff shall prioritize the application process as follows:
1. If the pre-printed postcard indicates that the person may be in immediate or ongoing need of medical care, the county eligibility staff shall determine the MI/MN eligibility within 20 days after the application date.
2. If the pre-printed postcard indicates that the person may need a medical examination or medical care in the next 30 days or more, the county eligibility staff shall determine the applicant's MI/MN eligibility within 30 days after the application date.
3. If the circumstances described in subsections (A)(1) or (A)(2) are not applicable, the county eligibility staff shall determine the person's MI/MN eligibility within 60 days after the application date.

B. Initiating the eligibility process. If the county eligibility staff receives the preprinted postcard, the county eligibility staff shall initiate the MI/MN determination process by mailing to the applicant a notice that includes:
1. The fact that the county eligibility staff is prepared to take the MI/MN application and interview the applicant;
2. At least 1 interview date and time and the name of the county eligibility staff who will take the applicant's application and interview the applicant;
3. An instruction that the applicant shall immediately contact the county eligibility staff to select 1 of the scheduled interview dates and times or an alternative date and time;
4. A warning that failure to attend the scheduled interview without arranging an alternative interview may prevent the county eligibility staff from making an eligibility determination as specified under subsection (A);
5. A reminder that the applicant shall:
   a. Review the MI/MN eligibility and verification requirements that the applicant received with the notice of AHCCCS categorical termination, and
   b. Make every effort to obtain appropriate verification of information required to determine eligibility and bring it to the interview; and
6. An instruction that the applicant shall also bring the notice of termination of AHCCCS categorical eligibility to the interview.

C. Appointment scheduling. The county eligibility staff shall arrange the appointment at a time that permits an eligibility determination within the time limits established in subsection (A), but is not so close to the date of the postcard to be an undue burden on the applicant.

D. Termination notice as verification. The county eligibility staff shall accept the notice of AHCCCS categorical termination as verification of the applicant's Arizona residency, unless termination was due to nonresidence in Arizona.

E. Applicability of other requirements. Except as otherwise provided in this Section, all requirements of this Article applicable to applications for MI/MN coverage shall apply to applications initiated under this Section.

R9-22-1605. Responsibilities of the Head-of-Household for MI/MN Eligibility

A. Completion of the application. To complete an application for MI/MN coverage, the head-of-household shall:
1. Complete all required forms by:
   a. Answering each question completely and accurately in the Section provided, and
   b. Signing and dating each form;
2. Complete the face-to-face interview, or if permitted under R9-22-1608(D), telephonic interview, as scheduled;
3. Provide complete and accurate information regarding all factors that are necessary for determining eligibility;
4. Sign the Statement of Truth;
5. Obtain available verification specified in this Article and provide it to the county eligibility staff within the time limits in R9-22-1609;
6. Identify sources of necessary verification that is not provided under subsection (A)(5) and authorize the release of information to the county eligibility staff;
7. Identify all health or accident insurance policies and benefits and any cause of action against any applicant or entity that is potentially liable for costs incurred by household members;
8. Agree to file claims for 1st-and 3rd-party insurance benefits and to cooperate with the Administration to recover the cost of the medical care or treatment provided by the Administration including assigning rights to the Administration;
9. Complete the screening form and, if appropriate, application process for categorical eligibility under R9-22-1610; and
10. Sign a statement agreeing to cooperate with the application process for S.O.B.R.A. or other categorical eligibility if required, under R9-22-1610.

B. Reporting changes. The head-of-household shall:
1. Notify the county eligibility staff within 10 calendar days of any demographic or any other change that may affect eligibility; and
2. Provide information and verification necessary for processing an interim change under R9-22-1630 within 10 days following the county eligibility staff's written request.

C. Cooperation. The head-of-household shall cooperate with the Administration in a review of eligibility determination.

R9-22-1606. MI/MN Statement of Truth by the Head-of-Household

A. General requirements for the Statement of Truth.
1. The Administration shall publish a written Statement of Truth to be signed by the head-of-household in the presence of the county eligibility worker before an application is approved.
2. During the face-to-face interview, the county eligibility worker shall:
   a. Fully explain the Statement of Truth to the head-of-household,
   b. Request confirmation from the head-of-household that the Statement of Truth has been fully explained, and
   c. Request the head-of-household's signature only after the head-of-household confirms full understanding of the statement.

B. The Statement of Truth shall include:
1. The head-of-household's sworn oath or affirmation under penalty of perjury that all oral and written statements made as part of the application for AHCCCS coverage are true and correct to the best of the head-of-household's knowledge;
2. The requirement to report changes under R9-22-1630;
3. The requirement to provide DES, county, state, or federal reviewers with the information and verification of the information necessary to:
   a. Determine correct eligibility; or
   b. Conduct a quality control review;
4. The fact that refusal or failure to cooperate with the requirements of subsection (B)(3) shall result in the denial or discontinuance of AHCCCS coverage;
5. The fact that provision of incorrect information may result in denial or discontinuance;
6. An authorization for AHCCCS, the county eligibility staff, and DES to investigate and contact any sources necessary to establish the accuracy of information pertaining to eligibility for AHCCCS coverage;
7. The definition of fraud and the penalties that may result from fraudulently obtaining AHCCCS coverage;
8. The assignment and transfer to the Administration of all rights to insurance and any other 1st-and 3rd-party liability benefits, up to the actual cost of care received, accruing to the head-of-household or other household member during the certification period;
9. An agreement to apply for any health or accident insurance benefits to which an eligible household member is entitled;
10. An agreement that, if the need for medical treatment covered by AHCCCS is a result of negligence and if money or property is recovered by a household member from the negligent party or that party's insurer:
    a. AHCCCS and the health care provider shall be entitled to liens against the recovery, and
    b. That a release of a claim against the negligent party is not valid unless joined in by AHCCCS.
11. The head-of-household's right to appeal if:
    a. The county eligibility staff or DES takes adverse action on the application;
    b. The county eligibility staff does not take action on the application within 30 days following the application date and the head-of-household has not agreed to extend this time limit; or
    c. DES does not take action on the application within 45 days following the application date.
12. A statement that information contained in the case record is confidential and may be given only to certain persons as specified by law or regulation.

R9-22-1607. Notice of Reapplication

The county eligibility staff shall notify the Administration if:

A. An applicant applies for MI/MN eligibility, and

B. Within the last 10 months, the head-of-household that included the applicant failed or refused to cooperate with the Administration's eligibility quality control review and analysis.

R9-22-1608. County Responsibility for Completion of MI/MN Eligibility Determination

A. Provision of space. The county eligibility staff shall provide sufficient space and materials for the head-of-household to complete the application forms.

B. Provision of assistance. The county eligibility staff or a person authorized by the eligibility staff shall assist the head-of-household in completing the application forms if assistance is requested.
1. The person providing the assistance shall indicate on the form that assistance was provided.
2. The person providing assistance may provide assistance before or during the face-to-face interview.

C. Face-to-face interview. The county eligibility staff shall complete the face-to-face interview when the head-of-household is present at the scheduled appointment time. During a face-to-face interview, the county eligibility staff shall:
1. Inform the head-of-household of:
   a. The MI/MN eligibility requirements defined in this Article;
   b. The responsibilities of the head-of-household specified in R9-22-1605;
   c. The confidential nature of information received;
   d. The time-frames for completion of the application specified in R9-22-1609;
   e. The date coverage begins for approved applicants and the enrollment process;
   f. The length of certification period, under R9-22-1615, that may apply to approved household members;
   g. The E.P.S.D.T. benefits specified in R9-22-102, if there are children in the household; and
   h. The right to appeal specified in R9-22-802;
2. Present the Statement of Truth and obtain the head-of-household's signature under R9-22-1606;
3. Explain the requirement to screen for S.O.B.R.A. and other categorical eligibility under R9-22-1610 and provide each applicant with the appropriate screening form;
4. Obtain the head-of-household's signature on the Intent to Cooperate form and assist the head-of-household in the completion of additional forms for required applications under R9-22-1610;
5. Review each question on the application forms and supplements with the head-of-household and ensure that answers are recorded on the forms. Unless the applicant requests assistance in the completion of the application forms as provided in subsection (B), the county eligibility staff shall add information in the designated areas only; and
6. Request verification of information required under this Article.

D. Telephone interviews. The county eligibility staff may conduct a telephone interview if:
1. The person on whose behalf the application was initiated is a patient who is hospitalized:
   a. Outside of the patient's county of residence; or
   b. In the county of residence in medical isolation and there is no head-of-household in the county of residence who may apply on the patient's behalf; or
2. The head-of-household lives in a geographically isolated area identified by the Director; or
3. The person is an applicant with a disability and requests a reasonable accommodation, such as a sign language interpreter.

E. Eligibility worker responsibility during telephone interview. During the telephone interview, the eligibility worker shall:
1. Read the Statement of Truth to the head-of-household at the beginning of the telephone interview and determine the head-of-household's understanding;
2. Obtain demographic information about all household members and enter the information on the application forms;
3. Ask all questions on the application forms and obtain and record the answers;
4. Request the information and complete the screening form to identify potential S.O.B.R.A. and categorical eligibility under R9-22-1610;
5. Inform the head-of-household that verification of all information received during the telephone interview is required prior to the eligibility determination;
6. Inform the head-of-household of all factors listed in subsections (C)(1)(a) through (C)(1)(h);
7. Obtain confirmation of the household's mailing address and inform the head-of-household that all forms requiring signatures will be sent to that address and, except as provided in subsection (F), shall be signed and returned to the county eligibility staff within 30 days following the date of the application; and
8. Establish by mutual agreement, follow-up arrangements to obtain verifications of all factors of eligibility and to obtain the required signatures.

F. Extension of 30 day time-frame. The county eligibility staff may extend the 30 day time-frame in subsections (E)(7) if the head-of-household remains incapacitated and unable to complete the application process. The extension ends when the conditions of either subsections (D)(1)(a) or (D)(1)(b) no longer apply.

G. Requirement to complete face-to-face interview. Except as permitted in subsection (D), the county eligibility staff shall complete an interview with the head-of-household before making an eligibility determination. After the interview, the county eligibility staff shall:
1. Complete any appropriate worksheets and other necessary forms to justify eligibility decisions;
2. Obtain the head-of-household's signature and date for any additional entries on the application;
3. Compare information received during and after the interview with existing case information to identify differences and to determine their effect on the eligibility determination;
4. Notify the Administration under R9-22-1618 if a household member is eligible;
5. Issue a Notice of Action under R9-22-1617;
6. Discontinue eligibility under R9-22-1617 and R9-22-1618 if a telephonic interview has been approved and after 30 days there have been no extensions or the end of the extension as specified in subsection (F); and:
   a. The county eligibility staff has not received the required verification; or
   b. The head-of-household has not signed and returned the required forms.

H. Statement of Completion. The Administration shall publish a Statement of Completion to be signed by the eligibility staff certifying completion of the application process.
1. The statement shall include the eligibility staff's confirmation that the eligibility worker has:
   a. Advised the person of:
      i. The right to appeal any eligibility decision,
      ii. The obligation to report all changes affecting

eligibility, and

iii. The penalties for fraud, misrepresentation, and intentional omissions;

b. Requested and received confirmation that the person fully understands these rights, obligations, and penalties; and

c. Completed the investigation of the AHCCCS eligibility required by law.

2. The county eligibility staff shall sign the Statement of Completion at the time of the eligibility decision except when the application is denied because an interview is not completed.

R9-22-1609. MI/MN Timeliness Requirements

A. Requirement for counties. Except for determinations for an applicant whose complete MI/MN-S.O.B.R.A. dual application has been forwarded to DES under R9-22-1610, the county eligibility staff shall make the eligibility determination within the 30 days following the application date. This 30 day limit may be extended under subsection (C).

B. Requirement for the head-of-household. The head-of-household shall provide the county eligibility staff with verification of information requested by the county eligibility staff under this Article by the 30th day following the application date.

C. Extension of an allotted time. The county eligibility staff shall extend the time period allotted in subsections (A) and (B) 1 time, by 30 days, if the head-of-household requests additional time to obtain or provide the requested verification and complies with subsection (D).

D. Informed consent. The county eligibility staff shall inform the head-of-household in writing that the requested extension may result in a delay or lapse in AHCCCS coverage. The head-of-household shall agree in writing to the extension and acknowledge the potential delay or lapse in AHCCCS coverage.

E. Extending time period. The county eligibility staff shall not extend the time period unless the county eligibility staff receives the signed agreement within the initial 30 day period.

F. Processing an untimely application. When processing an untimely application, for the purpose of counting income under R9-22-1626, the county eligibility staff shall base the 3-month-income-period on a deemed application date instead of the original application date.

R9-22-1610. Forwarding Applications to Obtain Categorical Eligibility

A. Screening requirement. During or before the face-to-face interview, the county eligibility staff shall use the screening form required by A.R.S. §§ 36-2905; 36-2905.03 and 11-297 to screen all applications to determine each household member's potential for categorical eligibility.

B. A concurrent application for categorical eligibility. The head-of-household of a household that includes 1 or more of the following shall also apply at the same time for categorical coverage for the household member, unless the household member is already categorically eligible:

1. A pregnant woman;
2. A dependent child born on or after October 1, 1983;
3. A hospitalized applicant, not listed in subsections (B)(1) or (B)(2), who is:
   a. A dependent child born before October 1, 1983;
   b. The parent or specified relative of a dependent child if:
      i. The child resides with a parent or specified relative, and
      ii. Deprivation exists under R9-22-1424, or
4. A nonhospitalized person not listed in subsections (B)(1) or (B)(2) applying for SESP under R9-22-1613 who:
   a. Is listed in subsection (B)(3)(a),
   b. Is age 65 or older, or
   c. Claims blindness or disability as defined by 42 U.S.C. 1382c(a)(2) and (3).

C. Required cooperation. The head-of-household and household members listed in subsection (B) shall cooperate with the application process for categorical eligibility and shall sign a statement of Intent to Cooperate. The statement shall be on a form prescribed by the Administration and shall explain:

1. The requirement to concurrently apply for categorical eligibility, and
2. That failure to cooperate shall result in denial or discontinuance of eligibility.

D. Application forwarding requirements. If the household includes 1 or more persons who are listed in subsection (B) the county eligibility staff and the head-of-household shall complete the following:

1. The county eligibility staff shall assist the head-of-household for an applicant listed in subsections (B)(1) or (B)(2) in completing an application for S.O.B.R.A. at the same time as completing the MI/MN application unless a pending S.O.B.R.A. application exists with DES. The county eligibility staff shall send the S.O.B.R.A. application to DES within 30 days following the date the county eligibility staff receives the signed application.
2. The county eligibility staff shall assist the head-of-household for an applicant listed in subsections (B)(3) or (B)(4)(a) to complete an application for medical assistance under R9-22-1407(D). The county eligibility staff shall forward the application and all available documentation and verification to DES under subsection (D)(4).
3. The head of a household that includes an applicant listed in subsections (B)(4)(b) or (B) (4)(c) shall apply for SSI-linked FESP for that person. The county eligibility staff shall forward the application forms, available documentation, and verification to the Administration under subsection (D)(4).
4. The county eligibility staff shall forward documents in subsections (D)(2) and (D)(3) by:
   a. The 30th day after the date the county eligibility staff receives the signed application; or
   b. The 3rd day after the county completes the determination of eligibility, whichever date occurs 1st.
5. After the county eligibility staff forwards an application to DES or the Administration, the county eligibility staff shall not request additional verification from the household if that verification is necessary solely for determination of categorical eligibility other than S.O.B.R.A. The county eligibility staff shall continue to receive and forward to DES or the Administration any verification that was requested prior to forwarding the application or that was requested for the MI\MN determination.
6. Application forwarding requirements are waived if:
   a. The applicant listed in subsection (B) has an application for medical assistance pending determination by DES, or
   b. The applicant listed in subsection (B)(4) has an application for medical assistance pending determination by the Administration.

E. Conditions for approval. If the county eligibility staff forwards an application for an applicant listed in subsection (B) to DES or the Administration under subsection (D), the county eligibility staff shall not approve that applicant for coverage unless the applicant meets the requirements for eligibility under this Article and:
1. The applicant is hospitalized;
2. DES or the Administration denies the applicant's application for categorical eligibility for a reason other than refusal to cooperate; or
3. The applicant is listed in subsections (B)(1) or (B)(2); and:
   a. The applicant meets the citizenship or alien status requirement for MI/MN eligibility under R9-22-1624;
   b. The county eligibility staff forwards a complete application with all required documentation and verification to DES under subsection (D)(1); and
   c. DES has not, within 10 working days following DES' receipt of the forwarded application, completed a determination of the applicant's eligibility for categorical eligibility.

F. County requirement to inform. Whenever the county eligibility staff is required to forward an application to another agency under this Article, the county eligibility worker shall explain to the head-of-household during the face-to-face interview:
1. That the application will be forwarded to another agency and the name of the agency,
2. What additional actions the head-of-household shall be required to take in order to establish eligibility,
3. The penalties for refusal to cooperate, and
4. The potential for delay in a determination of eligibility.

R9-22-1611. Eligibility for Medicare Beneficiaries

A. Exceptions. This Section does not apply to an person who:
1. Has had an organ transplant requiring prescribed immuno-suppressant drugs; or
2. May not be enrolled in a Medicare HMO because:
   a. The person resides in a county where no Medicare HMO operates, or
   b. The person has a preexisting medical condition or receives Medicare hospice services.

B. Eligibility restriction. A recipient of Medicare benefits is ineligible for MI/MN coverage if:
1. The person is enrolled in a Medicare HMO; or
2. The person voluntarily discontinued Part B Medicare benefits after being found ineligible for MI/MN under this Section.

C. Eligibility limitation. An applicant who is not enrolled in a Medicare HMO but is eligible or may be eligible to be enrolled in a Medicare HMO, may receive MI/MN coverage, if eligible, with the following restrictions:
1. An person who has Medicare Parts A and B may receive MI/MN coverage for no longer than the month of certification plus the 2 following calendar months.
2. An person who receives Medicare Part A benefits, but who does not receive Medicare Part B benefits, may receive MI/MN coverage only:
   a. Until the date that Medicare Part B benefits are available; or
   b. Until the date Medicare Part B would be available if the person had applied for Medicare Part B benefits during the 1st Medicare general enrollment period following approval for MI/MN coverage.
      i. Medicare general enrollment periods and resulting dates of Medicare Part B coverage are specified in 42 CFR 406 and 407.
      ii. For this subsection, the Medicare general enrollment period ends if less than 1 month of the Medicare general enrollment period remains.
3. If an person becomes eligible for Medicare while MI/MN eligible, the county eligibility staff shall:
   a. At the time of approval of MI/MN, advise the person to apply for those benefits during the initial Medicare enrollment period as specified in 42 CFR 406 and 407; and
   b. Not approve a person for MI/MN coverage again, after the Medicare Part A and Part B benefits are effective, or would be effective, if the person had applied for Medicare Part B benefits during the initial enrollment period.
4. The county eligibility staff shall provide the person a minimum of 2 months from the last day of the initial enrollment period to enroll in a Medicare HMO.

D. Undue Hardship. The Administration shall determine that a person has undue hardship if the applicant:
1. Meets all requirements for MI/MN benefits under this Article; and
2. Is determined ineligible for the Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary program, as defined in A.R.S. § 36-2971 et. seq. due solely to excess income and either:
   a. Received Medicare Part A benefits as specified in 42 CFR 406 and 407 prior to July 1, 1996 and did not have Medicare Part B coverage as of July 1, 1996 or has applied to receive Medicare Part B; or
   b. Received Medicare Part A and B or Medicare Part A benefits only and all Medicare HMOs operating in the applicant's county of residence charge a monthly premium.

E. Undue hardship payment:
1. The Administration shall reimburse the Medicare Part B premiums paid by the person who is subject to undue hardship under subsection (D)(2)(a).
2. The Administration shall pay Medicare HMO premiums directly to the Medicare HMO or reimburse Medicare premiums paid by the person who is subject to undue hardship under subsection (D)(2)(b). The Administration shall not pay:
   a. More than the lowest Medicare HMO monthly premium available if there is more than 1 Medicare HMO in the applicant's county of residence, or
   b. If coverage from a premium-free Medicare HMO becomes available in the applicant's county of residence.
3. Once every 6 months, the Administration shall review the status of each person who receives payments or on whose behalf payments are made for undue hardship under this Section. The Administration may approve an additional 6-month extension of the payments, provided the person continues to meet the requirements in subsection (D).

R9-22-1612. State-Funded Coverage for Children

A. Eligible low income children program (ELIC).
1. Eligibility for ELIC coverage is determined by the county eligibility staff who shall determine eligibility for ELIC coverage for every child under age 14 who is a member of a household that is ineligible for MI/MN

coverage due solely to exceeding income requirements of A.R.S. § 36-2905.

2. To be eligible for ELIC coverage under A.R.S. § 36-2905.03(C), a child shall:
   a. Be a member of a household that:
      i. Applies for MI/MN eligibility under this Article;
      ii. Meets all eligibility requirements for MI\MN eligibility except has annual income determined under R9-22-1626 that exceeds the income limits prescribed by A.R.S. § 36-2905 but is less than or equal to the federal poverty limit established by the United States Department of Health and Human Services; and
   b. Be under 14 years of age.
3. The county eligibility staff shall verify a child's age following the requirements of R9-22-1622 before approving ELIC eligibility for the child.
4. The county eligibility staff shall initiate a denial or discontinuance of ELIC eligibility for a child under age 14 if:
   a. A reason exists under R9-22-1616 to deny or discontinue MI/MN coverage except the income limit shall be as prescribed by A.R.S. § 36-2905.03(C), or
   b. The household limit exceeds the limit prescribed by A.R.S. § 36-2905.03.
5. The county eligibility staff shall initiate a discontinuance effective the end of the month of the ELIC child's 14th birthday.
6. Notices of Action for the ELIC program shall conform to the requirements of R9-22-1617.
7. The head-of-household for a child eligible for ELIC has all rights and responsibilities of a head-of-household for a child who is eligible for MI/MN.

B. MI/MN newborn eligibility.
   1. A newborn child of an MI/MN mother is eligible for AHCCCS coverage from the date of the child's birth until the last day of the next month, if the child continues to reside with the MI/MN eligible mother;
   2. To request continued coverage for the child beyond the time-frame in subsection (B)(1), the head-of-household shall report the birth to the county eligibility staff under R9-22-1630 or apply for redetermination under R9-22-1631.

C. Eligible assistance children program (EAC).
   1. Eligibility for EAC coverage is determined by DES.
   2. To be eligible for the EAC program, a child shall meet the requirements of A.R.S. § 36-2905.03(B).

R9-22-1613. State Emergency Service Program (SESP)

A. General Requirement. The county eligibility staff shall determine an applicant's eligibility for SESP only if:
   1. The applicant applies for MI/MN coverage under this Article;
   2. The applicant does not meet the citizenship or alien status requirement of R9-22-1624 or is unable to verify citizenship or alien status; and
   3. The county eligibility staff determines that the applicant meets all other requirements in this Article for:
      a. MI/MN coverage, or
      b. ELIC coverage.

B. To be approved for SESP, an applicant shall:
   1. Meet the requirements in subsection (A), and
   2. Cooperate with the application for categorical coverage if required under R9-22-1610.

C. Face-to-face interview. During the face-to-face interview, the county eligibility staff shall fulfill the requirements of R9-22-1608 and explain the following to the head-of-household for an applicant who may be considered for SESP coverage:
   1. Medical coverage is limited to emergency services designated by the Director;
   2. Labor and delivery for a pregnant woman are covered. Prenatal care is covered only as indicated in subsection (D);
   3. The requirement to provide verification of continued emergency medical services beyond the end of the month of approval; and
   4. The procedure for having the certification period extended.

D. Prenatal care. A pregnant woman who is eligible for SESP is eligible for coverage of prenatal care if the pregnant woman has resided in the United States under color of law continuously since before August 22, 1996.
   1. The county eligibility staff shall verify color of law by obtaining:
      a. The applicant's signature under penalty of perjury that the pregnant woman is lawfully residing in the United States;
      b. Unexpired documentation issued by the United States Department of Justice that the pregnant woman entered the United States before August 22, 1996, and is permitted to remain; and
      c. Verification that the woman is pregnant under R9-22-1615.
   2. The pregnant woman shall apply for categorical eligibility and cooperate with the application process under R9-22-1610, but if found eligible for that coverage is eligible for prenatal care under SESP.
   3. The county eligibility staff shall notify the Administration that the pregnant woman meets the eligibility requirements for prenatal care under SESP.
   4. The certification period for prenatal care under SESP shall be the same as the certification period for SESP for a pregnant woman under R9-22-1615.

E. Extended certification. If eligible, an applicant shall receive an extended SESP certification period under R9-22-1615 by providing verification from a medical provider of continued need for coverage.

F. Denial or discontinuance of eligibility. The county eligibility staff shall deny or initiate discontinuance of a person's SESP eligibility if:
   1. Reason exists under R9-22-1616, other than failure to meet citizenship or alien status requirements, to deny or discontinue MI/MN coverage;
   2. The person or the head-of-household states that there is no need for medical services; or
   3. The county eligibility staff approves or extends SESP coverage for months other than the month of determination under R9-22-1615, and the member, head-of-household, or provider informs the county eligibility staff that the member is no longer pregnant or no longer requires continued care under the program.

G. Notice of Action. Notices of Action for SESP shall conform to the requirements of R9-22-1617.

H. Rights and responsibilities. The head-of-household for an SESP applicant or member has all rights and responsibilities of a head-of-household for an MI/MN applicant or member under this Article.

R9-22-1614. Reserved

R9-22-1615. Certification Periods

A. General certification period for MI/MN. The certification period for MI/MN coverage shall begin on the date of determination and, except as indicated in subsections (B) and (C), shall end on the last day of the 6th full calendar month following the date of determination.

B. Short certification period for MI/MN. The MI/MN certification period for a person shall begin on the date of determination and end on:
   1. The same end date as already approved household members if the certification period is for an added household member or a household member whose eligibility is delayed, or
   2. The last day of the 2nd full calendar month following the date of determination if the household member is:
      a. A Medicare recipient who is eligible to receive Medicare services from a Medicare HMO under R9-22-1611; or
      b. Hospitalized and potentially eligible for categorical coverage but not potentially eligible for S.O.B.R.A. At the end of the short certification period, the county eligibility staff shall extend the certification period to 6 months if the head-of-household cooperates with the DES application process and DES either denies categorical eligibility or has not completed the determination of the household member's categorical eligibility under R9-22-1414.

C. Extended certification period for an MI/MN pregnant woman.
   1. The MI/MN certification period for a pregnant woman shall begin on the date of determination and end on the last day of the month after the estimated date of delivery or the end date under subsection (A), whichever date occurs last.
   2. The pregnant woman shall provide verification of her pregnancy and estimated date of delivery. The verification shall be a written statement signed by a licensed physician, physician assistant, nurse, or midwife.
   3. The county eligibility staff shall adjust an existing MI/MN certification period for a woman who provides verification to the county eligibility staff that she is pregnant, or that the estimated date of delivery is different from the originally verified date.

D. Certification period for ELIC. The certification period for ELIC coverage shall begin on the date of determination and end on the earliest date as follows:
   1. The last day of the 6th calendar month following the date of determination;
   2. The same end date as already approved household members if the certification period is for added household members or household members whose eligibility is delayed; or
   3. The last day of the month of the household member's 14th birthday.

E. Certification period for SESP. The certification period for SESP shall begin on the date of determination and end on the last day of the month of determination.
   1. The county eligibility staff may approve a longer SESP certification period under the following conditions:
      a. The county eligibility staff may initially approve or extend SESP certification period for up to 3 full calendar months if:
         i. A medical provider certifies that the applicant will need extended emergency medical care; or
         ii. A pregnant woman will still be pregnant during the additional months.
      b. The county eligibility staff may initially approve the month following the month of determination if the date of determination is 1 of the last 5 days in the month of determination.
   2. The county eligibility staff shall not approve or extend an SESP certification period beyond:
      a. The last day of the month of delivery for a pregnant woman,
      b. The last day of the month of the child's 14th birthday for a child who is approved under R9-22-1613(A)(3)(b), or
      c. The last day of the 6th calendar month following the month of determination of the household's eligibility.
   3. Before extending an SESP certification period, the county eligibility staff shall:
      a. Contact the head-of-household,
      b. Identify any interim changes, and
      c. Evaluate the effect of any interim change that occurred since the approval of eligibility under R9-22-1630.

F. Termination of certification period. The county eligibility staff shall discontinue eligibility and terminate the MI/MN, ELIC, or SESP certification period if a person becomes ineligible for coverage under this Article before the end of the certification period. Termination is effective:
   1. On the date the county eligibility staff communicates the discontinuance to the Administration under R9-22-1618, if the reason for discontinuance is:
      a. A voluntary request for discontinuance by the head-of-household, or
      b. The person is an inmate in a public penal institution or is in a public mental hospital;
   2. On the date of death if the member is deceased; or
   3. For all other reasons:
      a. On the last day of the month that the county eligibility staff communicates discontinuance to the Administration under R9-22-1618, or
      b. On the last day of the following month if the county eligibility staff communicates discontinuance to the Administration after:
         i. 12:00 noon on the 2nd day before the last day of the month; or
         ii. The time that the Administration communicates, in advance, to the county eligibility staff.

R9-22-1616. Denial or Discontinuance of MI/MN Eligibility

A. Ineligibility of households. The county eligibility staff shall send a denial or discontinuance notice for all household members under any of the following circumstances:
   1. The household's annual income, determined under R9-22-1626, exceeds the limits specified in A.R.S. §§ 11-297 and 36-2905. The county eligibility staff shall not deny or discontinue eligibility if:
      a. A household member is incurring medical expenses that are eligible for deduction under R9-22-1626(F), and
      b. The household is expected to reach the allowable income limit within the 30 days following the application date.

2. The household's total countable liquid resources determined under R9-22-1627 exceed the $5,000 limit specified in A.R.S. §§ 11-297 and 36-2905.
3. The household's total countable resources determined under R9-22-1627 exceed the $50,000 limit specified in A.R.S. §§ 11-297 and 36-2905.
4. A household member transfers resources under R9-22-1628 for the purpose of meeting the resource limits specified in A.R.S. §§ 11-297 and 36-2905.
5. The head-of-household fails, within the time-frames as specified in R9-22-1609 or R9-22-1630, to provide information or verification required to determine eligibility. The county eligibility staff shall not deny or discontinue eligibility for this reason unless the required information or verification has been requested in writing by the county eligibility staff and the head-of-household has been given a minimum of 10 days from the date of a written request to provide the information or verification.
6. The head-of-household refuses to cooperate in providing information or verification that is required under this Article.
7. The head-of-household does not sign the application forms when required under this Article.
8. The head-of-household fails to participate in the face-to-face interview, under R9-22-1602, R9-22-1603, or R9-22-1631.
9. The head-of-household fails or refuses to cooperate with the application process under R9-22-1605.
10. The head-of-household requests a withdrawal of an application or discontinuance of all household members' eligibility for the program.
11. The head-of-household fails or refuses to cooperate with the Administration's eligibility quality control review or analysis.
12. The head-of-household refuses to assign health or accident benefits to the Administration as specified in R9-22-1605.
13. The applicant applying for the household is a dependent child, except as permitted under R9-22-1601(D).

B. Ineligibility of an individual household member. The county eligibility staff shall send a denial or discontinuance notice for an applicant under any of the following circumstances:

1. The person's whereabouts are unknown.
2. The person is not a resident of Arizona as defined in A.R.S. § 36-2903.01 and R9-22-1623.
3. The person is a dependent child whose application is not filed by a qualified applicant.
4. The person an inmate in a public institution.
5. The person is a patient of a public mental hospital.
6. The person is deceased. If the applicant dies, and within 2 days following the date of death, the county eligibility staff determines the applicant met all other eligibility requirements, the county eligibility staff shall approve the deceased applicant for MI/MN, ELIC, or SESP. The county eligibility staff shall then immediately discontinue the deceased applicant's MI/MN eligibility. This action will result in the availability of coverage under R9-22-1620, beginning 2 days before the date of determination and ending on the date of death.
7. The person is not a citizen of the United States or an alien under R9-22-1624.
8. The person is ineligible for coverage as specified in R9-22-1611.
9. The person is not a household member as specified R9-22-1625.
10. The person is eligible for medical assistance under Title XIX or Title XXI of the Social Security Act.
11. The person is an AHCCCS-disqualified spouse or an AHCCCS-disqualified dependent.
12. The person is ineligible for MI/MN, ELIC, or SESP coverage due to a refusal to cooperate with the Title XIX eligibility process as required by state law.
13. The head-of-household requests a discontinuance of the applicant's coverage.
14. The person is an adult and requests a discontinuance of the applicant's coverage.

R9-22-1617. Notice of Action for Eligibility

A. General requirement. The county eligibility staff shall prepare a Notice of Action stating the county eligibility staff's determination of each household member's eligibility or ineligibility and of any changes in eligibility status.

B. Form of the Notice of Action. The notice shall be on a form prescribed by the Administration.

C. Required information. The notice shall include the following information:

1. The program for which the county eligibility staff is making the determination,
2. The type of action,
3. The effective date of the action under R9-22-1615,
4. The end date of newly approved or existing coverage even if unchanged,
5. The right to request a hearing and the procedure and time limits for making the request,
6. The address and telephone number of the county eligibility office where the determination is completed,
7. The name or the identification number registered with the Administration of the eligibility worker who completes the eligibility determination, and
8. The date the notice is mailed or hand-delivered to the head-of-household.

D. Notices of adverse actions. A notice of denial, discontinuance, or proposed discontinuance shall include the reason for the action and the law or regulation.

E. Avoidance of proposed discontinuance. A notice of proposed discontinuance shall include an explanation of the right to provide proof of eligibility within 15 days following the notice to avoid discontinuance under R9-22-1619.

F. Distribution of the notice to the head-of-household. On the date of determination, the county eligibility staff shall send the Notice of Action by mail or deliver it personally to the head-of-household.

G. Notice to providers. The county eligibility staff shall notify the provider who initiated the application for a household member under R9-22-1603 of the household member's eligibility or ineligibility.

R9-22-1618. Communication of Eligibility Determinations to the Administration

A. General. The Administration shall process eligibility actions communicated to the Administration by the county eligibility staff.

B. Communication. With the exception of denials, the county eligibility staff shall communicate demographic changes and all eligibility actions to the Administration by telephone or by other means approved by the Administration.

C. Information. The county eligibility staff member shall provide the following to the Administration:

1. The staff member's identification number and eligibility site;
2. The type of action;
3. Personal and demographic information about the applicant for whom the action is taken;
4. The AHCCCS recipient and case identification numbers, if available;
5. The beginning date and the end date of eligibility, as appropriate; and
6. Other information that the Administration requests in writing.

D. Time-frames.

1. The county eligibility staff shall provide the Administration the following information on the date of determination:
   a. Approval or extension of eligibility;
   b. Discontinuance of eligibility if the county eligibility staff receives verification that the applicant:
      i. Is an inmate in a public institution or in a public mental hospital;
      ii. Does not reside in Arizona;
      iii. Is eligible for Title XIX coverage in another state or territory; or
      iv. Is deceased; and
   c. Discontinuance of eligibility if the head-of-household or an adult household member submits a written request for discontinuance.
2. The county eligibility staff shall communicate a discontinuance of eligibility for any other reasons on the 16th day following the date of determination.
3. The county eligibility staff shall communicate demographic changes that do not affect eligibility on the day that the county eligibility staff verifies the change.

R9-22-1619. Rights Following Receipt of a Notice of Denial or Discontinuance of Coverage

A member or head-of-household may take the following actions in response to an adverse action by the county eligibility staff:

1. Apply again for eligibility under this Article;
2. Appeal the denial or discontinuance under R9-22-802; or
3. Stop a proposed discontinuance by providing proof of eligibility to the county eligibility staff within 15 days after the date of the Notice of Action.

R9-22-1620. Retroactive Coverage for MI/MN, ELIC, and SESP

The Administration or contractors shall be responsible for covered emergency medical services as defined by R9-22-102 which are provided to a MI/MN, ELIC, or SESP eligible person during the 2 days before the date that a county eligibility staff determines a person eligible and the county communicates the eligibility determination to the Administration as specified in R9-22-1618. The Administration shall not be responsible for the costs of emergency medical services that are deducted from the household's annual income under R9-22-1626.

R9-22-1621. Reserved

R9-22-1622. Verification of Information for MI/MN Eligibility

A. Verification. The applicant shall provide the county eligibility staff with verification of all information necessary to complete the determination of eligibility in the initial application process or at the time of a redetermination or interim change.

1. The county eligibility staff shall not approve an applicant's eligibility until all required verification is received.
2. The county eligibility staff shall offer to assist the applicant in obtaining verification and shall provide assistance if authorized by the applicant.

B. Procedure for obtaining verification. Except where otherwise indicated in this Article, the county eligibility staff shall adhere to the following procedure for requesting and obtaining verification:

1. The county eligibility staff shall 1st request documented verification that is available at the time of the interview. Documented verification is evidence in written form provided on an official document from an applicant qualified to have knowledge of the information provided. Documented verification shall be secured from the applicant or from a 3rd-party.
2. If documented information is not immediately available at the time of the interview, the county eligibility staff shall accept collateral verification. Collateral verification is information presented other than on an official document and obtained from a person who has knowledge of the information. The applicant shall identify potential sources of collateral verification for each item of information.
3. If sources of collateral verification are not available, the county eligibility staff shall request that the applicant obtain documented information that is not immediately available at the time of the interview.
4. If the county eligibility staff and the applicant exhaust all potential sources of collateral and documented verification and determine that documented and collateral verification are not available, the county eligibility staff shall accept a written declaration as verification. The written declaration shall be signed and dated by the head-of-household.
   a. Verification is not available if:
      i. A record does not exist for the information that needs to be verified; or
      ii. A record exists but the person or entity able to provide the information refuses to provide it to both the county eligibility staff and the applicant.
   b. Verification that is available only upon payment of a fee is not considered unavailable.

C. Reverification waiver. The county eligibility staff shall not reverify information for determinations or redeterminations of eligibility if information that is not subject to change is contained in case records and verified under this Article.

D. Resolution of inconsistencies required. The county eligibility staff shall reconcile any inconsistencies between the verified information and the case file before approving eligibility unless the inconsistencies have no effect on the eligibility determination.

R9-22-1623. Residence Requirements for MI/MN Eligibility

A. General Requirements. To be eligible for MI/MN coverage, an applicant shall be a resident of Arizona. An MI/MN applicant may establish Arizona residency on behalf of all members of the household by:

1. Signing an affidavit attesting to:
   a. Current residence in Arizona and intent to remain indefinitely, and
   b. Abandonment of residency outside of Arizona, and
2. Meeting the Arizona residency requirements under A.R.S. § 36-2903.01.

B. Residency of household groups. If the head-of-household meets the requirements of subsection (A), the county eligibility staff will consider the residency requirements met for all household members unless the county eligibility staff has evidence that:
1. A dependent child household member may not meet the requirements of subsection (A). The head-of-household shall provide documented or collateral verification as defined in R9-22-1622, showing the child resides with the household; or
2. An adult household member may not meet the requirements of subsections (A) and (B). An adult household member shall independently establish Arizona residency as specified in this Section.

C. Frequency of required verification. The county eligibility staff shall verify Arizona residency:
1. For the household before approving any application except an application for redetermination; and
2. For a household member;
   a. Any time the county eligibility staff questions residency for the household member; or
   b. Before the county eligibility staff adds a household member to the household.

D. Determinations by a County Special Eligibility Officer. If a County Special Eligibility staff determines residency as specified in A.R.S. § 36-2903.01, the County Special Eligibility staff shall not make a determination of residency based solely on the Statement of Truth or a statement of intent and shall require collateral verification.

E. Retention of residency. The county eligibility staff shall not consider an absence from the state longer than 60 consecutive days to be temporary unless good cause is established for a longer absence.
1. A person shall continue to be an Arizona resident during a temporary absence from the state if the person does not establish a permanent residence outside of Arizona and continues existing Arizona-linked activities including:
   a. Motor vehicle registration,
   b. Income tax filing,
   c. Voter registration, and
   d. Receipt of Arizona public assistance.
2. A person shall report, in advance to the county eligibility staff, an absence from the state that is expected to last more than 60 consecutive days.

F. Verification of county residency. The head-of-household shall confirm the county of residence of the household by:
1. Providing 3rd-party documented or collateral evidence of the household's residential address or physical location if no permanent residence exists, and
2. Signing a statement that all members of the household reside in the county.

G. Opportunity to establish residency. The head-of-household or spouse shall be given 30 days from the application date, or until determined ineligible for another reason, to meet the requirements of this Section. The time may be extended for an additional 30 days under R9-22-1609.

R9-22-1624. Citizenship and Alien Status Requirements for MI/MN Eligibility

A. General requirements. To be eligible for MI/MN coverage, an applicant shall be a United States citizen or meet the alien status requirements of A.R.S. § 36-2903.03.

B. Affidavit. Each adult applicant shall sign an affidavit under penalty of perjury that the applicant is a citizen of the United States or an alien with lawful alien status. A parent, specified relative, or legal guardian shall sign the affidavit for each minor in the household. This requirement does not apply to an applicant who verifies citizenship under subsections (C)(1), (C)(2) and (C)(3).

C. Verification of citizenship. The head-of-household shall provide the county eligibility staff with documentation of United States citizenship for all applicants who are citizens. Documentation is 1 of the following:
1. A birth certificate issued by any state or the District of Columbia or an outlying possession of the United States;
2. A religious certificate, recorded in the United States within 3-months following birth, indicating birth in the United States or outlying possession of the United States;
3. A document issued by the United States Department of State or the United States Department of Justice indicating that the applicant is a citizen of the United States;
4. An affidavit, signed under penalty of perjury, attesting to birth in the United States or 1 of its outlying possessions.
   a. A parent or specified relative may sign on behalf of a dependent child. All other household members shall sign the affidavit;
   b. The affidavit of birth may be combined with the affidavit of citizenship required under subsection (B).
5. Verification of registration to vote in the United States; or
6. A document or documents not listed in this subsection that verify that the applicant is a citizen of the United States at birth under 8 U.S.C. 1401.

D. Lawful alien status. The head-of-household shall provide the county eligibility staff with documentation of lawful alien status for all applicants who claim to be lawful aliens. Documents of lawful alien status are:
1. Documents issued by the United States Department of Justice verifying that an applicant is a qualified alien under A.R.S. § 36-2903.03 and the applicant's date of legal entry into the United States;
2. Documents indicating that the applicant is a Native American born in Canada and has at least 50% Native American ancestry.
3. Documents indicating that the applicant, who was born outside the United States and cannot verify United States Citizenship under this Section, is a member of an Indian Tribe as defined in 25 U.S.C. 450 b(e).

R9-22-1625. Household Composition for MI/MN Eligibility

A. Identification of household. A household consists of:
1. A single person residing alone;
2. All persons who normally share a common residence and are linked by any of the following relationships:
   a. Spouse to spouse,
   b. Parent to dependent child whether natural or adopted, or
   c. Specified relative to dependent child;
3. A spouse living separately from members of the same household if:
   a. A spouse resides in Arizona in a licensed nursing care institution, licensed supervisory care facility, or certified adult foster care facility because of a mental or physical disabling condition verified by doctors, or
   b. A spouse is temporarily absent under R9-22-1623(E), from the common residence due to work-

ing or seeking employment away from the common residence; or

4. A dependent child who is absent from the home because of school attendance within Arizona or because of residence in a residential facility is a member of the child's parent's household unless:
   a. The child lives with the other parent,
   b. The child lives with a specified relative,
   c. The child is pregnant, or
   d. The child lives with the child's own children.

B. Exclusions from the household. The following persons are not members of the household. The county eligibility staff shall not exclude any other person who is a member of the household under subsection (A).
1. Except as provided by A.R.S. §§ 11-297, 36-2905, and 36-2905.03, a person who is eligible as any of the following is not a member of the household unless that person is a person for MI/MN eligibility due to termination of categorical eligibility within 30 days before termination from categorical eligibility.
   a. A categorically eligible person who is covered for all medical services under A.R.S. § 36-2907; or
   b. A Qualified Medicare Beneficiary under A.R.S. § 36-2971.
2. A dependent child who is pregnant or who is a parent who resides with that dependant child's own children and with a specified relative, is not a member of specified relative's household, unless the specified relative is the dependent child's legal guardian.

C. Verification of relationship and household composition. The county eligibility staff shall verify relationship and living arrangements including absent spouses or absent children under subsections (A)(3) and (A)(4) whenever:
1. There is a change in address; or
2. Before approving MI/MN eligibility.
   a. The county eligibility staff may accept a declaration of the head-of-household for verification that applicants reside together unless it is inconsistent with other information known to the county eligibility staff;
   b. The county eligibility staff shall verify the reason for absence of absent household members under R9-22-1622.

R9-22-1626. Annual Income for MI/MN Eligibility

A. Determination of annual income. The county eligibility staff shall determine annual income under A.R.S. §§ 36-2905, 11-297, and 36-2905.03 by:
1. Adding any countable income received during the 3-month-income period by:
   a. Household members;
   b. A trust if the resources of the trust are included in determining the household's resources under R9-22-1627;
   c. A corporation if the resources of the corporation are included in determining the household's resources under R9-22-1627. The county shall calculate the income received and expenses incurred by such a corporation the same as self-employment income and expenses of a household member.
2. Multiplying the result of subsection (A)(1) by 4;
3. Deducting medical expenses that are deductible under subsection (F); and
4. If the applicant is a qualified alien who has a sponsor under A.R.S. § 36-2903.03, adding the annual income of the sponsor and the spouse of the sponsor.
   a. The county eligibility staff shall determine and verify the sponsor's and the sponsor's spouse's annual income by the same procedure used to determine the applicant's annual income under this Section.
   b. The county eligibility staff need not conduct a face-to-face interview with the sponsor or the sponsor's spouse for this purpose.

B. Receipt of income. Except as indicated in subsection (C), the county eligibility staff shall consider income available to the household to be received on the earliest of:
1. The date it is received by a household member, made available to be picked up by a household member, or paid to someone else on a household member's behalf. Payment may be in the form of cash, check, or other negotiable instrument.
2. The date the household member receives a check in the mail if the check is not available to be picked up by a household member. This date may be:
   a. The date on the check if the check is mailed before the date on the check so as to be received on the date of the check;
   b. The 5th day after the date on the check if the check is mailed on the date printed on the check; or
   c. A later date if later receipt is verified under R9-22-1622;
3. On the date the income is deposited in a bank or other financial institution by any entity or applicant, including another owner of the account, into an account that is owned under R9-22-1627 by a household member.

C. Deemed date of receipt. The county eligibility staff shall consider income to be received on a date other than the date it became available if the income:
1. Is available annually, semi-annually, or at another regular periodic interval of more than 3 but no more than 12 months:
   a. The county eligibility staff shall divide the income by the number of weeks between payments; and
   b. The county eligibility staff shall consider 1 portion received weekly until exhausted, beginning on the date the income is available under subsection (B);
2. Is available as a lump-sum at the option of the recipient or of the payor. The county eligibility staff shall consider lump-sum income received in portions on the dates the portions would be or would have been available if paid separately and not in a lump sum;
3. Is 1-time income that is not lump-sum income, but is designated by the payor to cover a specified period of time:
   a. The county eligibility staff shall divide these payments into a number of portions equal to the number of weeks in the specified period; and
   b. Shall consider 1 portion received weekly until exhausted, beginning on the date the income is available under subsection (B); or
4. Is 1-time-income that is not designated by the payor to cover a specified period:
   a. The county eligibility staff shall divide these payments into 4 equal portions; and
   b. Shall consider 1 portion received on the day it is available under subsection (B) and 1 portion received on the same day of each 3rd month until the income is exhausted.

D. Disregarded income. The following income shall be disregarded for purposes of determining eligibility for this Article:

1. Income received from a household member under R9-22-1625;
2. Income received from a categorically eligible person who resides with the applicant and except for categorical status would be a member of the household.
3. Income earned by a dependent child until the child's 16th birthday if the child is not emancipated or expressly emancipated;
4. Income received as conversion of assets;
5. Income in-kind;
6. Gratuitous payments made directly to a 3rd-party by friends, relatives, charities, or agencies on behalf of the applicant or household;
7. Reimbursement for medical care received from a 1st-or 3rd-party liability source;
8. Reimbursement for loans to or expenditures made on behalf of a nonhousehold member;
9. A loan received by a household member, to the extent that the loan is repaid by a household member before the application date, or if not repaid, there is a dated, written repayment agreement at the time of the financial exchange, which is signed by the household member;
10. The 1st of 4 regular monthly income or the 1st of 7 regular 2-times-a-month income that is received during the 3-month income period, if those payments are to the same household member from the same payor;
11. Loans, grants, scholarships, and fellowships funded by the United States Department of Education or benefits received under the Veterans Education Assistance Program or the Bureau of Indian Affairs student assistance program for educational purposes;
12. Educational, commuting, relocation, and job search allowances provided under the Trade Readjustment Act;
13. Reimbursement for training-related expenses, subsistence and maintenance allowances, on-the-job training wages, or other wages related to vocational rehabilitation and paid to applicants engaged in a veteran, federal, or state-sponsored vocational rehabilitation program;
14. VISTA volunteer compensation;
15. Compensation paid to volunteers over age 60 in the Retired Senior Volunteer Program, the Foster Grandparent Program, and the Older American Community Service Program;
16. Tax credit granted under A.R.S. § 43-1072, earned credit for property taxes for residents 65 years of age or older;
17. Indian Claims Commission or Court of Claims judgment funds (also known as per capita payments to Indian tribes), including interest on the funds while in trust, regardless of the tribe or the public law number;
18. Alaska Native Claims Settlement Act benefits that are tax exempt;
19. Emergency Disaster and Energy Assistance Payments;
20. Public relocation assistance payments;
21. Condemnation awards for the condemnation of the principal place of residence;
22. Income that an applicant or the applicant's household receives as a result of a settlement agreement or a judgment in a lawsuit brought against a manufacturer or distributor of Agent Orange;
23. Reparation and restitution payments under 42 U.S.C. 1396a(r); and
24. Refunds of state and federal income tax payments.

E. Deductions from income. The county eligibility staff shall allow the following deductions from gross income that is not disregarded in determining eligibility:

1. Court-ordered spousal maintenance, division of income, alimony, or child support owed by a household member that is paid by a household member during the 3-month income period;
2. Unreimbursed employee work-related expenses, that were paid by a household member during the 3-month income period, may be deducted from earned income only. These include:
   a. Expenses incurred solely because they are required by the employer,
   b. Union or association dues, and
   c. Employment agency costs.
3. Cost of child care or disabled dependent care incurred because of employment or job search or both paid by a household member during the 3-month income period;
4. Educational expenses including tuition, books, lab fees, other mandatory student fees;
   a. The county eligibility staff may deduct educational expenses only from countable educational income;
   b. If the county eligibility staff determine that educational income from which the expense is deducted is deemed received over time under subsection (C), and the expense is for tuition or other costs for the same time period, the county eligibility staff shall deduct the entire expense from the income before dividing the income;
5. Expenses of producing self-employment incurred during the 3-month income period. The county eligibility staff may deduct self-employment expenses only from self-employment income;
6. The amount deducted from income for the purpose of repaying an overpayment to a household member;
7. Legal and attorneys' fees withheld from a settlement or judgment that results in income to a household member;
8. Funeral and burial expenses. The county eligibility staff may deduct these expenses only from death benefit income; and
9. Income received by a household member as a representative, on behalf of another person who is entitled to the income, to the extent that it is not used for the representative or the representative's household.

F. Medical expense deduction. The county eligibility staff shall subtract deductible medical expenses when determining the household's annual countable income. The county eligibility staff may deduct only those medical expenses that:

1. Were incurred by:
   a. A household member,
   b. A person who would be a household member but for exclusion under R9-22-1625(B),
   c. A deceased spouse or dependent child of a household member, or
   d. A person who was a dependent child of a household member when the expense was incurred but who is no longer a dependent child;
2. Were incurred during the 12 months immediately before the date of determination for eligibility;
3. Are not subject to any applicable 1st-or 3rd-party payment or payment by the Administration; and
4. Are the financial responsibility of a household member. Costs are not a household member's responsibility if the costs have not been paid by a household member and:

a. Another person has paid them without expectation of repayment,
b. Another person has paid the expenses as a loan but there is no repayment agreement signed by the household member charged with making the repayment,
c. The creditor has canceled the charges before the eligibility determination, or
d. The charges are owed to the Administration and the Administration has taken no action and there is no plan to collect the amount.

G. Income verification exceptions. The county eligibility staff shall verify all information pertaining to the calculation of annual income under the requirements specified in R9-22-1622 except:
1. For verification of self-employment income, the head-of-household's declaration may serve as the primary verification source;
2. The county eligibility staff shall accept only documented or collateral verification for:
a. Self-employment expenses deducted under subsection (E)(5); and
b. Deductible medical expenses; and
3. The county eligibility staff may not accept the declaration of the head-of-household or the sponsor of a qualified alien or sponsor's spouse as verification of the sponsor's or sponsor's spouse's income.

R9-22-1627. Resources for MI/MN Eligibility

A. When to calculate resources. The county eligibility staff shall evaluate the value of resources as of the application date or latest interim change under R9-22-1630, whichever date occurred last.

B. Included resources. The county eligibility staff shall include the following resources in determining eligibility:
1. Owned by household members as defined in R9-22-1625, except resources excluded in subsection (D). The owner of the resources is the person who holds legal title to or provides evidence of ownership of a resource if no valid title exists.
a. If a liquid resource is owned by more than 1 person, the liquid resource shall be counted in full unless:
i. The applicant demonstrates by clear and convincing evidence that all or part of the resource is unavailable, and
ii. The applicant has neither contributed to nor benefited from the liquid resource; and
b. If a nonliquid resource is owned by more than 1 owner, the nonliquid resource shall be presumed owned by all owners in equal shares unless the applicant demonstrates by clear and convincing evidence that a different allocation shall be used, based upon each owner's proportionate net contribution.
2. Resources held in trust if:
a. The trust is funded with resources owned by or due to a household member and a household member is a beneficiary,
b. The trust is funded by a nonhousehold member and the trustee and all beneficiaries are household members, or
c. The trust is funded by a nonhousehold member and the trustee is a household member and has the ability to withdraw funds from the trust for the trustee's own use.
3. Resources owned by a corporation if all shares of the corporation are owned by household members.
4. Resources owned by a sponsor of a qualified alien applicant, or the sponsor's spouse, if those resources are included under A.R.S. § 36-2903.03.
a. The county eligibility staff shall verify the sponsor's or the sponsor's spouse's resources as specified in subsection (F).
b. The county eligibility staff is not required to conduct a face-to-face interview with the sponsor or the sponsor's spouse.

C. Calculation of resources: The county eligibility staff shall determine the value of all household resources as follows:
1. Except as specified in subsection (E), calculate the total amount of the liquid resources.
2. Calculate the equity value of each nonliquid resource:
a. The county eligibility staff shall use the assessor's full cash value as the value of real property, except the county eligibility staff shall use the market value of real property if:
i. The assessor's value of real property does not include the value of permanent structures on that property, or
ii. There is no assessor's evaluation of the property,
b. The county eligibility staff shall use the market value of all other nonliquid resources;
c. The county eligibility staff shall determine a household member's equity of a nonliquid resource by subtracting the amount of valid encumbrances on that resource from the assessor's full cash value or market value of the nonliquid resource;
d. The equity value of a resource shall not be less than 0; and
3. Determine the net worth of all household resources by adding the totals determined in subsections (C)(1) and (C)(2).

D. Excluded resources. When determining the value of resources owned by the household the county eligibility staff shall not count the value of:
1. Household furnishings;
2. Personal items and clothing;
3. Household pets;
4. Property that is not available because it is the subject of litigation in a court of law;
5. The unexpended portion of educational grants, loans, scholarships, and fellowships left on account in a financial institution during the period of time for which the funds were intended;
6. Public relocation assistance moneys;
7. Separate property of an AHCCCS disqualified spouse up to $75,000. The county eligibility staff shall calculate the value of an AHCCCS-disqualified spouse's property under subsection (C);
8. Tools and machinery used for business excluding cars, trucks, or other motor vehicles;
9. Business inventory;
10. Tools and machinery not used for business if the aggregate value is $500 or less;
11. Wedding rings and engagement rings;
12. Money that an applicant or the applicant's household receives as a result of a settlement agreement or a judgment in a lawsuit against a manufacturer or distributor of Agent Orange if the money is identifiable and held separately from other money; and

13. Funds from reparation and restitution payments under 42 U.S.C. 1396a(r).

E. Provision for special treatment. For the purposes of this Section, the following resources shall be counted as nonliquid:
1. Condemnation awards of the principal place of residence, up to the assessed value of the property, for 12 months from the date of receipt or until the date of purchase of a new principal place of residence, whichever date occurs 1st; and
2. The principal balance due on a written sales contract or mortgage if the seller no longer owns the resource sold.

F. Verification of resources. The ownership and value of all property and resources for household members shall be verified prior to an eligibility determination under the requirements and time-frames specified in R9-22-1622, except:
1. The head-of-household's declaration shall not be accepted to verify an encumbrance if subtraction of the amount of the encumbrance is necessary to bring the household's resources within the resource limits specified in A.R.S. § 36-2905.
2. Once verified, the county eligibility staff shall not reverify the ownership and value of real property more than annually unless the household is within $5,000 of the total resource limit specified in A.R.S. § 36-2905.
3. The head-of-household's declaration of value for cash on-hand, jewelry, and tools and machinery, shall be acceptable verification unless there is reason to believe an appraisal of any item might result in ineligibility.
4. The value of excluded nonliquid resources, other than separate property of an AHCCCS- disqualified spouse, shall not be verified.
5. The county eligibility staff shall not accept the declaration of the head-of-household or the sponsor of a qualified alien or sponsor's spouse as verification of the sponsor's or sponsor's spouse's resources.

R9-22-1628. Transfer of Resources for MI/MN Eligibility

A. Ineligible members. All household members are ineligible if 1 household member transfers ownership of resources to a nonmember of the household within 3 years before the application date, unless:
1. Fair consideration was received for the entire value of transferred resources:
   a. Fair consideration for transferred resources means:
      i. 100% of the value if liquid resources are received in return for liquid resources transferred,
      ii. 100% of the value if debt is canceled in return for liquid resources transferred. Cancellation of debt is fair consideration only if the debt is legally enforceable and owed by a household member or a person who would be a household member except for categorical eligibility, and
      iii. 80% of the value transferred for transfers not included in subsections (A)(1)(a)(i) and (A)(1)(a)(ii);
   b. The county eligibility staff shall combine all consideration received for a transferred resource when determining whether fair consideration was received;
2. The entire equity value of the resource at the time of transfer, if added to the equity value of all other resources owned at the time of transfer, does not result in ineligibility;
3. Foreclosure or repossession of the resource was imminent at the time of transfer and there is no evidence of collusion in the transfer; or
4. The person who transferred the resources or the head-of-household establishes by clear and convincing evidence that the transfer was not made for the purpose of establishing eligibility.

B. Requirement for verification. The applicant for MI/MN coverage shall provide verification of:
1. The type, values, and equity of:
   a. All resources transferred during the 3 years before the application date,
   b. All resources owned at the time of the transfer, and
   c. All consideration received.
2. Imminent foreclosure for real property; or
3. Other reasons for transfer.

C. Form of verification.
1. A household member's declaration may be used to verify:
   a. The value and equity of all transferred resources, other than real property, at the time of transfer; and
   b. The value and equity of resources, other than real property, owned at the time of the transfer.
2. All other information requiring verification shall be verified under R9-22-1622.

R9-22-1629. Assignment of Rights

A. Assignment. As a condition of MI/MN eligibility, the head-of-household shall assign to the Administration the rights of all household members to medical support or payment of medical care from any liable party.

B. Assistance. The head-of-household shall identify and assist the Administration in pursuing 1st-or 3rd-party liability as defined in R9-22-101.

C. Verification. The county eligibility staff shall request and obtain verification information under R9-22-1622 for the 3rd-party liability.

R9-22-1630. MI/MN Interim Changes

A. Reporting requirements. The head-of-household shall report the following interim changes to the county eligibility staff by the 10th day following the change:
1. Change in household composition under R9-22-1025;
2. Change of address;
3. Increase in income due to increased salary, wages, unearned income, increased hours, a new job, gifts, inheritances, a legal settlement, or another new unreported source of income;
4. Addition to existing resources other than those resulting from the receipt of already reported income;
5. Change in alien status;
6. Change in 1st-or 3rd-party liability for health care expenses; or
7. Pregnancy of a household member or termination of a household member's pregnancy.

B. Processing other changes. If the county eligibility staff receives a report of an interim change identified in this Section from any source during a household member's certification period, the county eligibility staff shall identify any additional related changes and evaluate the effect of all changes on eligibility for continued benefits.
1. If verification of information is required to determine ongoing eligibility, the county eligibility staff shall request the verification required under R9-22-1622 from the head-of-household. The county eligibility staff shall make the request in writing within 2 working days from

the date a change is reported. The county eligibility staff shall allow the head-of-household 10 days following the date of written request to supply the verification and information requested.

2. Except as indicated in subsection (B)(3), upon receipt of required verification, the county eligibility staff shall evaluate interim changes under this Section. Upon completion of the evaluation of any change, the county eligibility staff shall provide notice of the result to:
   a. The head-of-household, under R9-22-1617, if the reevaluation results in:
      i. Discontinuance,
      ii. Change in coverage, or
      iii. Change in the certification period, or
   b. The Administration, under R9-22-1618, if the change:
      i. Adds a new eligible member,
      ii. Affects an existing member's eligibility or certification period,
      iii. Is demographic, or
      iv. Is for 1st-or 3rd-party liability for a member's health care.
3. If the county eligibility staff receives a report of an interim change less than 60 days before the end of the certification period, the county eligibility staff shall redetermine the household's eligibility under R9-22-1631.

C. Changes in household composition.
1. The head-of-household shall submit a new Part I Application to the county eligibility staff if there is a change in household composition.
2. If the county eligibility staff receives an application to add an applicant to a household that includes members who are eligible for MI/MN, ELIC, or SESP, the county eligibility staff shall:
   a. Evaluate the effect of the applicant's income or resources on the household's eligibility under subsections (D) and (E);
   b. If additional income and resources do not make the household ineligible and the additional applicant meets the requirements for eligibility, approve the additional applicant for coverage;
   c. Evaluate whether the applicant meets all other eligibility requirements under this Article;
   d. Screen the applicant for potential categorical eligibility under R9-22-1610 and, if appropriate, complete and refer the application to other agencies; and
   e. If added income and resources do not make the household ineligible, but the added applicant does not meet another requirement for eligibility, deny the added applicant for coverage.
3. If a person is no longer in the household, the head-of-household shall report the change to the county eligibility office and identify the remaining members of the household. The county eligibility staff shall:
   a. Discontinue eligibility for the person who is no longer a household member;
   b. Require redetermination of the household's eligibility under R9-22-1631, if the person is an adult who no longer resides with the household; and
   c. In all other cases, recalculate the annual income of the remaining household members only, based on their income and medical expenses used for the determination when eligibility was last approved:
      i. Compare the result to the income limit under R9-22-1626 for the adjusted household size, and
      ii. If the result is greater than the income limit, require a redetermination of the household's eligibility under R9-22-1631.

D. Changes in income. If a household reports and provides verification of additional income from increased salary, wages, unearned income, increased hours, a new job, gifts, inheritances, legal settlements, additional household members, or other new sources, the county eligibility staff shall:
1. Evaluate the effect of the income that is new or changed on the household's eligibility by:
   a. Multiplying new income or increases in old income that the household received during the 3-months before the date of the evaluation by 4;
   b. Adding the product in subsection (D)(1)(a) to the annual income determined for the household at the last determination;
   c. Comparing the total amount in subsection (D)(1)(b) to the income limit for the household sizes under A.R.S. §§ 11-297, 36-2905, and 36-2905.03
2. If the total amount in subsection (D)(1)(c) is greater than the income limit, the county eligibility staff shall complete a redetermination under R9-22-1631.
3. If the total amount in subsection (D)(1)(c) is less than the income limit, the county eligibility staff shall evaluate the potential for the change to result in ineligibility before the end of the certification period.
4. If the county eligibility staff identifies a date before the end of the certification period when there will be a potential for ineligibility, the county eligibility staff shall evaluate the change again, at that time, under this subsection.

E. Changes in resources. If a household reports additional resources, the county eligibility staff shall evaluate the household's resources under R9-22-1627. If either the value of liquid resources or the net worth of all resources exceeds the limit prescribed by A.R.S. §§ 11-297, 36-2905, and 36-2905.03, the county eligibility staff shall send written notice of discontinuance of eligibility of all household members to the head-of-household.

F. Changes in alien status. The county eligibility staff shall evaluate the effect of a change in an MI/MN or ELIC member's alien status on the member's eligibility if a change is reported or if a household member's alien status expires.
1. The county eligibility staff shall verify the household member's United States citizenship or alien status following a change under R9-22-1624.
2. If the household member no longer meets the citizenship or alien status requirements under R9-22-1624, the county shall:
   a. Discontinue the member's MI/MN or ELIC coverage under this Article; and
   b. Determine whether the member is eligible for SESP under R9-22-1613:
      i. If the member is eligible, approve SESP coverage; or
      ii. If the member is ineligible, deny SESP coverage.

G. Changes in pregnancy status. If a MI/MN, ELIC, or SESP member reports that she is pregnant the county eligibility staff shall either complete a redetermination of the pregnant member's household under R9-22-1631 or:

1. Explain the requirement to comply with the application process for eligibility under R9-22-1610;
2. Obtain the household member's signature on the statement of intent to cooperate;
3. Instruct the household member to apply at DES for S.O.B.R.A. or FES within 10 days and provide the address of where the household member can apply;
4. Discontinue MI/MN coverage if the household member does not apply within 10 days;
5. Discontinue MI/MN coverage if the household member applies but is denied for refusal to cooperate; and
6. Extend the household member's certification period under R9-22-1615 if the household member applies and is denied for a reason other than refusal to cooperate, and the household member provides verification of pregnancy to the county eligibility staff.

H. Changes in eligibility for household members. If a household member who is ineligible becomes eligible for MI/MN, ELIC, or SESP and another household member is already eligible for 1 of the programs, the county eligibility staff shall approve MI/MN, ELIC, or SESP coverage for the member who becomes eligible, under this Article.

I. Changes based on county-to-county relocation.
1. If a head-of-household reports an address change to the county eligibility staff in the old county of residence, the county eligibility staff shall:
   a. Provide a copy of the most recent Part I Application,
   b. Instruct the head-of-household to report the address change to the county eligibility staff in the new county of residence, and
   c. Provide the address of that office to the head-of-household.
2. If an applicant or the head-of-household provides verification of address change to the county eligibility staff in the new county of residence:
   a. The head-of-household shall complete and sign a new Part I Application with updated data;
   b. The head-of-household shall provide a copy of the old Part I Application to the county eligibility staff in the new county;
   c. The county eligibility staff shall request a copy of Part I Application or the information contained in the Part I Application from the previous county of residence, if the applicant or head-of-household does not provide a copy of the Part I Application to the new county eligibility staff;
   d. The county eligibility staff shall compare the new Part I Application and the Part I Application filed with the previous county of residence. The county eligibility staff shall review other changes under this Article.
   e. The county eligibility staff in the new county of residence shall communicate a change:
      i. For a head-of-household, to the Administration, under R9-22-1618; and
      ii To the previous county of residence which shall send a copy of the head-of-household's AHCCCS case file to the new county of residence within 5 working days.

J. Interim changes occurring before determination. Except for changes in income and death of the head-of-household, if a change occurs before the date of determination, the county eligibility staff shall determine eligibility based on the changed information. If a household's income increases after the application date but before the date determination and the county eligibility staff approves eligibility, the county eligibility staff shall evaluate the effect of the increase in income on eligibility, under subsection (D).

R9-22-1631. MI/MN Redeterminations

A. Requested redetermination. A head-of-household may seek to obtain continued coverage for the household under this Article by submitting an application for redetermination to the eligibility staff in the household member's county of residence.
1. Within 60 days before the expiration of the certification period under R9-22-1615; or
2. If a household member becomes pregnant.

B. Required redetermination. Under R9-22-1630 the county eligibility staff shall complete a redetermination if an adult household member leaves the residence and household and if the departure of the applicant may result in ineligibility of the remaining household members due to excess income.

C. County responsibility. If a household member requests redetermination, the county eligibility staff shall:
1. If the redetermination was not requested by the head-of-household, inform the head-of-household or any other adult household member that a redetermination of eligibility is required;
2. Schedule a face-to-face interview.
   a. If the county eligibility staff is able to meet in-person with the head-of-household to schedule the interview, the county eligibility staff shall schedule a mutually agreeable appointment time and provide the head-of-household with written confirmation of the appointment time, unless the interview is conducted immediately.
   b. If the county eligibility staff is unable to meet in-person with the head-of-household, the county eligibility staff shall schedule an appointment time and notify the head-of-household of the time, by mail, within 3 working days. The member may request to change the appointment once if the request to change is made before the originally scheduled interview. The county eligibility staff shall then change the interview to mutually agreeable time.
   c. If the county eligibility staff does not receive acknowledgment of the scheduled interview from the head-of-household, the county eligibility staff shall make at least 1 additional attempt to notify the head-of-household of the scheduled appointment.
3. The county eligibility staff shall determine the household's eligibility under this Article.

D. Head-of- household responsibility. If applying for redetermination, the head-of-household has all rights and responsibilities as a head-of-household applying for eligibility under this Article.

R9-22-1632. Reserved

R9-22-1633. Case Record for MI/MN Applications

A. General requirement. The county eligibility staff shall maintain a case record for every household that applies for MI/MN coverage.

B. Case record contents. The case record shall contain originals or copies of:
1. All documents that the county eligibility staff prepares, or receives from the household regarding the application

and determination of AHCCCS eligibility or ineligibility;
2. All documents regarding household members that the county eligibility staff receives from other sources;
3. Recordings of all information provided orally to the county eligibility staff by or regarding household members;
4. Recordings of all collateral verification the county eligibility staff obtains under R9-22-1622, including the identity and qualification of the party providing the verification and information being verified; and
5. Recordings identifying and explaining all actions the county eligibility staff takes regarding an application.

C. Required review. The county eligibility staff shall compare current information with a household's case record from prior applications to identify inconsistencies that may affect a new eligibility determination.

D. Retention of a case record. The county eligibility staff shall retain the case record for at least 3 years after date of the last entry or the date of a completed fraud investigation, whichever date occurs last.

E. Availability of the case record. The county eligibility staff shall make the case record available to the Administration or head-of-household upon written request.

F. Confidentiality. The county shall safeguard the case record and the information it contains under the requirements of R9-22-512.

R9-22-1634. Eligibility Office Locations and Hours of Operation

A. County responsibility. Each county shall provide the Administration with a written list of the locations and hours of operation of county offices where a person may submit an application for MI/MN eligibility.

B. Administration responsibility. The Administration shall notify the counties of the hours of operation for the receipt of notification telephone calls made by the county under R9-22-1618.

C. Timeliness of notice. The notices in subsections (A) and (B) shall be provided no less than 5 days before the effective date of a change.

D. Frequency of notice. Parties shall provide notice under this Section at least 1 time annually.

R9-22-1635. Reserved

R9-22-1636. Verification Review by the Director

At the discretion of the Director, the Administration shall review any county's applications, prior to notification of eligibility to the Administration under R9-22-1618, to ensure that the required verification and supporting case documentation are present.

ARTICLE 17. ENROLLMENT

R9-22-1701. Enrollment of a Member with an AHCCCS Contractor

A. General Enrollment Requirements
1. The Administration shall not enroll an applicant with a contractor if an applicant:
   a. Resides in an area not served by a contractor,
   b. Is eligible for the Federal Emergency Services (FES) program as defined in R9-22-101 or the State Emergency Services Program defined in R9-22-1613,
   c. Is eligible for a period less than 30 days from the date the Administration receives notification of a member's eligibility except for a member who is enrolled with CMDP or IHS as specified in this Section,
   d. Is eligible only for a prior quarter period as defined in R9-22-1432 except for a member who is enrolled with IHS as specified in this Section, or
   e. Is eligible only for a retroactive period of eligibility except for a member who is enrolled with IHS as specified in this Section.
2. The Administration shall enroll a member with:
   a. A contractor serving the member's geographical service area (GSA) except as provided in subsection (C); or
   b. The member's most recent contractor of record, if available, if the member's period of ineligibility and disenrollment from the contractor of record is for a period of less than 90 days except if:
      i. The member no longer resides in the contractor's GSA;
      ii. The contractor's contract is suspended or terminated;
      iii. The member was previously enrolled with CMDP but at the time of re-enrollment the member is not a foster care child;
      iv. The member chooses another contractor during the annual enrollment choice period; or
      v. The member was previously enrolled with a contractor but at the time of re-enrollment the member is a foster care child.

B. Fee-for-service coverage. A member not enrolled with a contractor under subsection (A)(1) shall obtain covered medical services from an AHCCCS registered provider on a fee-for-service basis as provided in 9 A.A.C. 7.

C. Foster care child. The Administration shall enroll a member with CMDP if the member is a foster care child under A.R.S.§ 8-512.

D. Categorical, EAC, ELIC, and state alien member.
1. Except as provided in subsections (A)(1), (A)(2)(b), and (C), a categorical, EAC, ELIC, or state alien member residing in an area served by more than 1 contractor, shall have freedom of choice in the selection of an contractor.
2. A Native American member may select IHS or another available contractor.
3. If the member does not make a choice, the Administration shall auto-assign the member to:
   a. A contractor based on;
      i Family continuity; or
      ii The auto-assignment algorithm; or
   b. IHS, if the member is a Native American living on reservation.

E. MI/MN member.
1. A MI/MN member, including Native Americans, shall not receive freedom of choice in the selection of an AHCCCS contractor, except as specified in subsection (G).
2. Except as provided in subsection (A)(2)(b), the Administration shall auto-assign a member as specified in subsection (D)(3).

F. Family Planning Services Extension Program. A member eligible under the Family Planning Services Extension Program, as defined in R9-22-1435, shall remain enrolled with the member's contractor of record.

G. Enrollment changes for a member.
1. A member may change contractors during the annual enrollment choice period.

2. The Administration may approve the transfer for an enrolled member from 1 contractor to another as specified in 9 A.A.C. 5, or as determined by the Director.
3. The Administration shall approve a change in contractor for any member if the change is a result of a grievance, resolved through the grievance process specified in 9 A.A.C. 8.
4. A categorical, EAC, ELIC, or state alien member may choose a different contractor if the member moves into a GSA not served by the current contractor or if the contractor is no longer available. If the member does not select a contractor, the Administration shall auto-assign the member as provided in subsection (D)(3).
5. The Administration shall auto-assign an MI/MN member to a different contractor as specified in subsection (E)(2), if the member moves into a GSA not served by the member's current contractor.

H. Newborn enrollment. A newborn shall be initially enrolled with a contractor as specified in R9-22-1703.

I. IHS. The provisions of subsections (A)(1)(a), (A)(2)(a), (A)(2)(b)(iv), (D), (E), (F), (G), and (H) apply if IHS is the contractor.

J. CMDP. The provisions of subsections (A)(1)(d),(A)(1)(e), and (H) apply if CMDP is the contractor.

R9-22-1702. Effective Date of Enrollment with a Contractor and Notification to the Contractor

A. Effective date of enrollment. Except as otherwise specified in this Article, the Administration shall enroll the member with the contractor effective on the date enrollment action is taken by the Administration.

B. Financial liability of the contractor. Except for the prior quarter period as defined in R9-22-1432, the contractor shall be financially liable for an enrolled member's care as specified in contract.

C. Notice to contractor. The Administration shall notify the contractor of each member's enrollment with the contractor as specified in contract.

R9-22-1703. Newborn Enrollment

A. General. A newborn child of an AHCCCS eligible mother is initially enrolled with a contractor based on the mother's enrollment status.

B. Financial liability for all newborns. The contractor shall be financially liable for the medical care of the newborn as specified in the contract.

C. Notification to mother. The Administration shall notify the mother of the newborn's enrollment.

D. Choice. The Administration shall give the mother of the categorical newborn an opportunity to select a different contractor for the newborn. The mother of a noncategorical newborn shall not receive freedom of choice in the selection of a contractor.

R9-22-1704. Categorical and EAC Guaranteed Enrollment Period

A. General.

1. The Administration shall grant a guaranteed enrollment period as provided in this Section to a categorical or EAC member if the member meets the following conditions:
   a. Becomes ineligible before receiving 5 full calendar months of enrollment with a contractor as specified in 42 U.S.C. 1396a(e)(2);
   b. If the date of ineligibility does not precede or equal the date of initial enrollment;
   c. Did not receive 5 full calendar months of categorical enrollment during a previous categorically eligible period;
   d. Did not receive 5 full calendar months of EAC enrollment during a previous EAC eligible period; and
   e. Does not meet any of the conditions listed in subsection (B).
2. The member may receive a separate guaranteed enrollment:
   a. For a maximum of 1 time if the member is a categorical member, and
   b. For a maximum of 1 time if the member is an EAC.
3. The guaranteed enrollment period shall begin on the effective date of the member's initial enrollment with the contractor, and shall continue for not less than 5 full calendar months.

B. Exceptions to guaranteed period. The Administration shall not grant a guaranteed enrollment period or shall terminate a guaranteed enrollment period as provided in subsection (C), if the member:

1. Is an inmate of a public institution as defined in 42 CFR 435.1009 except as provided in 9 A.A.C. 12;
2. Dies;
3. Moves out-of-state;
4. Voluntarily withdraws from the AHCCCS program;
5. Is adopted;
6. Is an EAC eligible and age 14; or
7. Is an EAC and fails or refuses to cooperate with the Title XIX eligibility process.

C. Disenrollment effective date. The Administration shall terminate any guaranteed enrollment period for which the member is not entitled effective on:

1. The date the member is admitted to a public institution specified in subsection (B), if known, or the date the Administration receives notification from the eligibility agency of the member's admission to a public institution;
2. The member's date of death;
3. The last day of the month in which the Administration receives notification from the eligibility agency that a member has moved out-of-state;
4. The date the Administration receives written notification of the member's voluntary withdrawal from the AHCCCS program;
5. The date adoption proceedings are initiated through a private party, if known, or on the last day of the month in which the Administration receives notification of the proceedings;
6. The last day of the month in which an EAC becomes age 14; or
7. The date the Administration receives notification from the eligibility agency that EAC eligibility will terminate because the responsible member fails or refuses to cooperate with the Title XIX eligibility process.

D. Retroactive adjustments. The Administration shall adjust the member's eligibility and enrollment retroactively as specified in subsection (C).

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

R9-28-101	Amend
R9-28-104	Repeal
R9-28-104	New Section
R9-28-401	Repeal
R9-28-401	New Section
R9-28-402	Repeal
R9-28-402	New Section
R9-28-403	Repeal
R9-28-403	New Section
R9-28-404	Repeal
R9-28-404	New Section
R9-28-405	Repeal
R9-28-405	New Section
R9-28-406	Repeal
R9-28-406	New Section
R9-28-407	Repeal
R9-28-407	New Section
R9-28-408	New Section
R9-28-409	New Section
R9-28-410	New Section
R9-28-411	New Section
R9-28-412	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 36-2932(B)(17) (K), (L), and (M)

   Implementing statute: A.R.S. §§ 36-401, 36-551, 36-2901(4)(b), 36-2932(M), 36-2933, 36-2934, 36-2934.01, 36-2936(D), 36-2937, 36-2939, 36-2940, 36-2947, and 44-101

3. **The effective date of the rules:**

   January 6, 1999

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   Notice of Rulemaking Docket Opening: 1 A.A.R. 2764, December 22, 1995.
   Notice of Rulemaking Docket Opening: 3 A.A.R. 1096, April 18, 1997.
   Notice of Rulemaking Docket Opening: 4 A.A.R. 256, January 16, 1998.
   Notice of Rulemaking Docket Opening: 4 A.A.R. 2845, October 2, 1998.
   Notice of Proposed Rulemaking: 4 A.A.R. 2825-2840, October 2, 1998.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Cheri Tomlinson, Federal and State Policy Administrator

   Address: AHCCCSA, Office of Policy Analysis and Coordination
   801 East Jefferson, Mail Drop 4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4198

   Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   Six of the 7 Sections (R9-28-401 and R9-28-403 through R9-28-407) in 9 A.A.C. 28, Article 4, that define the eligibility and enrollment requirements for ALTCS eligible persons and members, have been reorganized into 12 Sections to:

   - Add additional detail to clarify existing requirements and limitations in federal regulation or state statute,
   - Enhance the understandability and conciseness of existing language, and

- Implement recommendations from the May 2, 1995, 5-Year-Review.

The language in R9-28-402, *County Residency Requirements for ALTCS Enrollment*, has been moved to R9-28-712. 2 subsections in the current Article were deleted for the following reasons:

- *R9-28-404(B)* - Language regarding voluntary contributions used to offset the cost of ALTCS services was deleted as the result of a 5-Year-Review recommendation because statutory authority for the language has been repealed.

- *R9-28-407(C)* - Superfluous language regarding retroactive coverage for any period prior to the inception of the ALTCS program on December 19, 1988, for the developmentally disabled population and January 1, 1989, for the elderly and physically disabled population was deleted. Such time restraints are no longer applicable.

Changes are also made to 9 A.A.C. 28, Article 1 to comply with changes to 9 A.A.C. 28, Article 4.

7. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
   Not applicable.

8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

9. **The summary of the economic, small business, and consumer impact:**
   The following entities will be nominally impacted and will benefit from the changes which make the rule language more accurate and understandable:
   - The Administration,
   - ALTCS members,
   - ALTCS contractors, and
   - ALTCS providers.

10. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

	Rule Citation	Change
	General	The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, and punctuation changes throughout the Article.
	General	The Administration changed passive to active voice.
	R9-28-408(F)(3)(b)	The proposed rules have been amended to reference the new definition of assisted living facilities. The Administration is amending the language in another rule package to conform with all changes required in the AHCCCS Omnibus legislation.

11. **A summary of the principal comments and the agency response to them:**
    The Administration received comments from the Department of Economic Security. The Administration provided clarification through discussions with the Department. The Administration amended the proposed rules to reduce the number of acronyms used, and to accommodate recent statutory changes in the definition of Assisted Living Facilities.

12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
    Not applicable.

13. **Incorporations by reference and their location in the rules:**

9 A.A.C.28, Article 4 Description	Date	Location
42 CFR, Part 435, Subpart F	August 18, 1994	R9-28-402(A)
20 CFR 404.715 and 404. 716	June 7, 1978	R9-28-402(A)(1)(c)
42 U.S.C. 1382c(a)(2)	October 31, 1994	R9-28-402(A)(2)
42 U.S.C. 1382c(a)(3)	October 31, 1994	R9-28-402(A)(3)(a)

42 CFR 435.403	December 21, 1990	R9-28-403
1931 of SS Act (42 U.S.C. 1396u-1)	July 1, 1997	R9-28-407(A)(4)
42 U.S.C. 1382(a)(2)(B) and (b)	August 15, 1994	R9-28-407(B)
42 U.S.C. 1396r-5(h)(1)	September 30, 1989	R9-28-407(D)(5)
42 U.S.C. 1396r-5(c)	September 30, 1989	R9-28-407(D)(5)
20 CFR 416.1205	September 26, 1985	R9-28-407(E)(1)
1931 of SS Act (42 U.S.C. 1396u-1)	July 1, 1997	R9-28-408(A)(4)
42 U.S.C. 1382(a)	August 15, 1994	R9-28-408(B)
42 U.S.C. 1396u-1	July 1, 1997	R9-28-408(C)
42 U.S.C. 1396a(a)(17)(D)	November 5, 1990	R9-28-408(C)
42 U.S.C. 1382a(b)	August 22, 1996	R9-28-408(D)(1)(b)
42 CFR 435.602	August 22, 1994	R9-28-408(D)(1)(c)
42 U.S.C. 1396r-5(b)	October 1, 1993	R9-28-408(D)(1)(d)
20 CFR 416.1163(b)(1) and (2)	May 4, 1989	R9-28-408(D)(3)(b) and (c)
20 CFR 416.1165(b)	January 8, 1997	R9-28-408(D)(3)(d)
42 U.S.C. 1396u-1	July 1, 1997	R9-28-408(E)(4)
42 CFR 435.725	January 19, 1993	R9-28-408(F)
42 CFR 435.726	July 25, 1994	R9-28-408(F)
42 U.S.C. 1396r-5(b) and (d)	October 1, 1993	R9-28-408(F)(3) (a)
20 CFR 416.203	November 26, 1985	R9-28-408(G)
42 U.S.C. 1396p(c)(1)(A)	August 10, 1993	R9-28-409(A)
42 U.S.C. 1396p(c)(1)(B)	August 10, 1993	R9-28-409(B)
42 U.S.C. 1396p(c)(2)	August 10, 1993	R9-28-409(C)
42 U.S.C. 1396p(c)(1)(C)	August 10, 1993	R9-28-409(D)
42 U.S.C. 1396p(c)(2)(C)	August 10, 1993	R9-28-409(G)(1)
42 U.S.C. 1396r-5(c)	September 30, 1989	R9-28-410(B)
42 U.S.C. 1396r-5(c)(1)	September 30, 1989	R9-28-410(B)(1)(a)
42 U.S.C. 1396r-5(f)(2)	September 30, 1989	R9-28-410(B)(1)(b)
42 U.S.C. 1396r-5(c)(2)	September 30, 1989	R9-28-410(B)(1)(c)
42 U.S.C. 1396r-5(b)(2)	October 1, 1993	R9-28-410(C)(1)
42 U.S.C. 1396r-5(d)(1) and (2)	September 30, 1989	R9-28-410(C)(4)
42 U.S.C. 1396r-5(f)	September 30, 1989	R9-28-410(D)(1)

14. Was this rule previously adopted as an emergency rule? If so, please indicate the Register citation:
No.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 1. DEFINITIONS

Section
R9-28-101 General Definitions
~~R9-28-104 Eligibility and Enrollment Related Definitions~~
R9-28-104 Eligibility and Enrollment Related Definitions

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

~~R9-28-401 General Provisions~~
~~R9-28-402 Repealed~~
~~R9-28-403 Conditions of ALTCS Eligibility~~
~~R9-28-404 Post-eligibility Treatment of Income~~

~~R9-28-405 ALTCS enrollment and assignment~~
~~R9-28-406 ALTCS discontinuance and disenrollment~~
~~R9-28-407 ALTCS retroactive coverage~~
R9-28-401 General
R9-28-402 Categorical Requirements and Coverage Groups
R9-28-403 State Residency
R9-28-404 Citizenship and Qualified Alien Status
R9-28-405 Social Security Enumeration
R9-28-406 ALTCS Living Arrangements
R9-28-407 Resource Criteria for Eligibility
R9-28-408 Income Criteria for Eligibility
R9-28-409 Transfer of Assets
R9-28-410 Community Spouse
R9-28-411 Changes, Redeterminations, and Notices
R9-28-412 Enrollment with an ALTCS Program Contractor

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

~~A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:~~

~~Definition~~	~~Section or Citation~~
~~1. "AFDC"~~	~~R9-22-101~~
~~2. "Aggregate"~~	~~R9-22-107~~
~~3. "AHCCCS"~~	~~R9-22-101~~
~~4. "AHCCCS hearing officer"~~	~~R9-28-108~~
~~5. "ALTCS"~~	~~A.R.S. § 36-2932~~
~~6. "Alternative HCBS setting"~~	~~R9-28-101~~
~~7. "Ambulance"~~	~~R9-22-102~~
~~8. "Appeal"~~	~~R9-22-108~~
~~9. "Bed hold"~~	~~R9-28-102~~
~~10. "Behavior intervention"~~	~~R9-28-102~~
~~11. "Billed charges"~~	~~R9-22-107~~
~~12. "Capped fee-for-service"~~	~~R9-22-101~~
~~13. "Case management plan"~~	~~R9-28-101~~
~~14. "Case manager"~~	~~R9-28-101~~
~~15. "Case record"~~	~~R9-22-103~~
~~16. "Categorically eligible"~~	~~A.R.S. § 36-2934~~
~~17. "Certification"~~	~~R9-28-105~~
~~18. "CFR"~~	~~R9-28-101~~
~~19. "Clean claim"~~	~~A.R.S § 36-2904~~
~~20. "Comprehensive plan for delivery of services"~~	~~R9-28-105~~
~~21. "Contract"~~	~~R9-22-101~~
~~22. "Contractor"~~	~~R9-22-101~~
~~23. "County of fiscal responsibility"~~	~~R9-28-104~~
~~24. "Covered services"~~	~~R9-22-102~~
~~25. "CPT"~~	~~R9-22-107~~
~~26. "Day"~~	~~R9-22-101~~
~~27. "Designated representative"~~	~~R9-28-104~~
~~28. "Developmental disability"~~	~~A.R.S. § 36-551~~
~~29. "Diagnostic services"~~	~~R9-22-102~~
~~30. "Disenrollment"~~	~~R9-22-103~~
~~31. "DME"~~	~~R9-22-102~~
~~32. "Eligible person"~~	~~A.R.S. § 36-2931~~
~~33. "Emergency medical services"~~	~~R9-22-102~~
~~34. "Encounter"~~	~~R9-22-107~~
~~35. "Enrollment"~~	~~R9-22-103~~
~~36. "Estate"~~	~~A.R.S. § 14-1201~~
~~37. "Facility"~~	~~R9-22-101~~
~~38. "Factor"~~	~~R9-22-101~~
~~39. "Grievance"~~	~~R9-22-108~~
~~40. "Guardian"~~	~~R9-22-103~~
~~41. "HCBS"~~	~~A.R.S. §§ 36-2931 and 36-2939~~
~~42. "Home"~~	~~R9-28-101~~
~~43. "Home health services"~~	~~R9-22-102~~
~~44. "Hospital"~~	~~R9-22-101~~
~~45. "ICF-MR"~~	~~R9-28-101~~
~~46. "IHS"~~	~~R9-28-101~~
~~47. "IMD"~~	~~42 CFR 435.1009~~
~~48. "Inspection of care"~~	~~R9-28-105~~
~~49. "JCAHO"~~	~~R9-28-101~~
~~50. "Institutionalized individual"~~	~~R9-28-104~~
~~51. "License" or "licensure"~~	~~R9-22-101~~
~~52. "Medical record"~~	~~R9-22-101~~
~~53. "Medical services"~~	~~R9-22-101~~
~~54. "Medical supplies"~~	~~R9-22-102~~
~~55. "Medically eligible"~~	~~R9-28-104~~
~~56. "Medically necessary"~~	~~R9-22-101~~
~~57. "Member"~~	~~A.R.S. § 36-2931~~
~~58. "Minor"~~	~~R9-22-103~~
~~59. "NF"~~	~~42 U.S.C. 1396r(a)~~
~~60. "Noncontracting provider"~~	~~A.R.S. § 36-2931~~
~~61. "Occupational therapy"~~	~~R9-22-102~~
~~62. "Physical therapy"~~	~~R9-22-102~~
~~63. "PAS"~~	~~R9-28-103~~
~~64. "PASARR"~~	~~R9-22-103~~
~~65. "Pharmaceutical service"~~	~~R9-22-102~~
~~66. "Physician~~	~~R9-22-102~~
~~67. "Practitioner"~~	~~R9-22-102~~
~~68. "Primary care provider"~~	~~R9-22-102~~
~~69. "Primary care provider services"~~	~~R9-22-102~~
~~70. "Prior authorization"~~	~~R9-22-102~~
~~71. "Private duty nursing services"~~	~~R9-22-102~~
~~72. "Program contractor"~~	~~A.R.S. § 36-2931~~
~~73. "Provider"~~	~~A.R.S. § 36-2931~~
~~74. "Quality management"~~	~~R9-22-105~~
~~75. "Radiology services"~~	~~R9-22-102~~
~~76. "Reassessment"~~	~~R9-28-103~~
~~77. "Referral"~~	~~R9-22-101~~
~~78. "Reinsurance"~~	~~R9-22-107~~
~~79. "Respiratory therapy"~~	~~R9-22-102~~
~~80. "Respite care"~~	~~R9-28-102~~
~~81. "RFP"~~	~~R9-22-105~~
~~82. "Room and board"~~	~~R9-28-102~~
~~83. "Scope of services"~~	~~R9-22-102~~
~~84. "Speech therapy"~~	~~R9-22-102~~
~~85. "Spouse"~~	~~R9-22-103~~
~~86. "SSA"~~	~~P.L. 103-296, Title I~~
~~87. "SSI~~	~~R9-22-103~~
~~88. "Subcontract"~~	~~R9-22-101~~
~~89. "Utilization management"~~	~~R9-22-105~~
~~90. "Ventilator dependent"~~	~~R9-28-102~~

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
1. "211"	R9-28-104
2. "217"	R9-28-104
3. "236"	R9-28-104
4. "AFDC"	R9-22-101
5. "Aggregate".	R9-22-107
6. "AHCCCS"	R9-22-101
7. "AHCCCS hearing officer"	R9-22-108
8. "ALTCS"	A.R.S. § 36-2932
9. "ALTCS acute care services"	R9-28-104
10. "Alternative HCBS setting"	R9-28-101
11. "Ambulance"	R9-22-102
12. "Appeal"	R9-22-108
13. "Bed hold"	R9-28-102
14. "Behavior intervention"	R9-28-102
15. "Billed charges"	R9-22-107

16.	"Capped fee-for-service"	R9-22-101
17.	"Case management plan"	R9-28-101
18.	"Case manager"	R9-28-101
19.	"Case record"	R9-22-101
20.	"Categorically eligible"	A.R.S. § 36-2934
21.	"Certification"	R9-28-105
22.	"CFR"	R9-28-101
23.	"Clean claim"	A.R.S § 36-2904
24.	"Community Spouse"	R9-28-104
25.	"Community Spouse Resource Deduction"	R9-28-104
26.	"Comprehensive plan for delivery of services"	R9-28-105
27.	"Contract"	R9-22-101
28.	"Contractor"	R9-22-101
29.	"County of fiscal responsibility"	R9-28-107
30.	"Covered services"	R9-22-102
31.	"CPT"	R9-22-107
32.	"CSRD"	R9-28-104
33.	"Day"	R9-22-101
34.	"Developmental disability"	A.R.S. § 36-551
35.	"Diagnostic services"	R9-22-102
36.	"Disenrollment"	R9-22-117
37.	"DME"	R9-22-102
38.	"Eligible person"	A.R.S. § 36-2931
39.	"Emergency medical services"	R9-22-102
40.	"Encounter"	R9-22-107
41.	"Enrollment"	R9-22-117
42.	"Estate"	A.R.S. § 14-1201
43.	"Facility"	R9-22-101
44.	"Factor"	R9-22-101
45.	"Fair consideration"	R9-28-104
46.	"FBR"	R9-22-101
47.	"Grievance"	R9-22-108
48.	"Guardian"	R9-22-116
49.	"HCBS"	A.R.S. §§ 36-2931 and 36-2939
50.	"Home"	R9-28-101
51.	"Home health services"	R9-22-102
52.	"Hospital"	R9-22-101
53.	"ICF-MR"	R9-28-101
54.	"IHS"	R9-28-101
55.	"IMD"	42 CFR 435.1009
56.	"Inspection of care"	R9-28-105
57.	"Institutionalized"	R9-28-104
58.	"JCAHO"	R9-28-101
59.	"License" or "licensure"	R9-22-101
60.	"Medical record"	R9-22-101
61.	"Medical services"	R9-22-101
62.	"Medical supplies"	R9-22-102
63.	"Medically eligible"	R9-28-104
64.	"Medically necessary"	R9-22-101
65.	"Member"	A.R.S. § 36-2931
66.	"MMMNA"	R9-28-104
67.	"NF"	42 U.S.C. 1396r(a)
68.	"Noncontracting provider"	A.R.S. § 36-2931
69.	"Occupational therapy"	R9-22-102
70.	"PAS"	R9-28-103
71.	"PASARR"	R9-28-103
72.	"Pharmaceutical service"	R9-22-102
73.	"Physical therapy"	R9-22-102
74.	"Physician"	R9-22-102
75.	"Practitioner"	R9-22-102
76.	"Primary care provider"	R9-22-102
77.	"Primary care provider services"	R9-22-102
78.	"Prior authorization"	R9-22-102
79.	"Private duty nursing services"	R9-22-102
80.	"Program contractor"	A.R.S. § 36-2931
81.	"Provider"	A.R.S. § 36-2931
82.	"Quality management"	R9-22-105
83.	"Radiology"	R9-22-102
84.	"Reassessment"	R9-28-103
85.	"Redetermination"	R9-28-104
86.	"Referral"	R9-22-101
87.	"Reinsurance"	R9-22-107
88.	"Representative"	R9-28-104
89.	"Respiratory therapy"	R9-22-102
90.	"Respite care"	R9-28-102
91.	"RFP"	R9-22-105
92.	"Room and board"	R9-28-102
93.	"Scope of services"	R9-22-102
94.	"Speech therapy"	R9-22-102
95.	"Spouse"	R9-28-104
96.	"SSA"	P.L. 103-296, Title I
97.	"SSI"	R9-22-101
98.	"Subcontract"	R9-22-101
99.	"Utilization management"	R9-22-105
100.	"Ventilator dependent"	R9-28-102

B. General definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "AHCCCS" is defined in 9 A.A.C. 22, Article 1.
2. "ALTCS" means the Arizona Long-Term Care System as authorized by A.R.S. § 36-2932.
3. "Alternative HCBS setting" means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:
   a. For a person with a developmental disability (DD) specified in A.R.S. § 36-551:
      i. Community residential setting defined in A.R.S. § 36-551;
      ii. Group home defined in A.R.S § 36-551;
      iii. State operated group home defined in A.R.S. § 36-591;
      iv. Family foster home defined in 6 A.A.C. 5, Article 58;
      v. Group foster home defined in 6 A.A.C. 5, Article 59;
      vi. Licensed residential facility for persons with traumatic brain injury specified in A.R.S. § 36-2939(C); and
      vii. Behavioral health service agency specified in A.R.S. § 36-2939(B)(2) and 9 A.A.C. 20, Articles 6, 7, and 8 for Levels I, II, or III;
   b. ~~For persons who are elderly or physically disabled (EPD):~~For persons who are elderly or physically disabled (EPD), provided the facility, setting, or institution is registered with AHCCCS:
      i. Residential care institutions specified in A.R.S. § ~~36-2939(C);~~ 36-2939(C), including adult foster care ~~home~~ homes defined in A.R.S. § ~~36-401;~~ 36-401, adult care ~~home~~ homes defined in A.R.S. § 36-448, and Laws 1995, Ch. 256, amended ~~1997;~~ 1997, and supportive residential living ~~center~~ centers defined in A.R.S. § 36-1301;
      ii. Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. §

36-2939(C); and

iii. Behavioral health service agency specified in A.R.S. § 36-2939(C) and 9 A.A.C 20, Articles 6, 7, and 8 for levels I and II.

4. "Case management plan" means a service plan developed by a case manager that involves the overall management of a member's or eligible person's care, and the continued monitoring and reassessment of the member's or eligible person's need for services.
5. "Case manager" means an person who is either a degreed social worker, ~~or~~ a licensed registered nurse, or an person with a minimum of 2 years of experience in providing case management services to persons who are elderly and physically disabled or have developmental disabilities.
6. "CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.
7. "Contract" is defined in 9 A.A.C. 22, Article 1.
8. "Contractor" is defined in 9 A.A.C. 22, Article 1.
9. "Day" is defined in 9 A.A.C. 22, Article 1.
10. "Disenrollment" is defined in 9 A.A.C. 22, Article 1.
11. "Eligible person" has the meaning in A.R.S. § 36-2931.
12. "Enrollment" is defined in 9 A.A.C. 22, Article 1.
13. "Facility" is defined in 9 A.A.C. 22, Article 1.
14. "Factor" is defined in 9 A.A.C. 22, Article 1.
15. "HCBS" means home and community based services defined in A.R.S. §§ 36-2931 and 36-2939.
16. "Home" means a residential dwelling that is owned, rented, leased, or occupied at no cost to the ~~member~~ member, including a house, mobile home, apartment, or other similar shelter. A home is not a facility, setting, or institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a:
    a. Health care institution defined in A.R.S. § 36-401;
    b. Residential care institution defined in A.R.S. § 36-401;
    c. Community residential facility defined in A.R.S. § 36-551; or
    d. Behavioral health service facility defined in 9 A.A.C. 20, Articles 6, 7, and 8.
17. "Hospital" is defined in 9 A.A.C. 22, Article 1.
18. "ICF-MR" ~~has the meaning~~ means an intermediate care facility for the mentally retarded and is defined in 42 CFR 435.1009 and 440.150.
19. "IHS" means the Indian Health Services.
20. "JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.
21. "License" or "licensure" is defined in 9 A.A.C. 22, Article 1.
22. "Medical record" is defined in 9 A.A.C. 22, Article 1.
23. "Medical services" is defined in 9 A.A.C. 22, Article 1.
24. "Medically necessary" is defined in 9 A.A.C. 22, Article 1.
25. "Member" has the meaning in A.R.S. § 36-2931.
26. "NF" means nursing facility and is defined in 9 A.A.C. 22, Article 1.
27. "Noncontracting provider" has the meaning in A.R.S. § 36-2931.
28. "Program contractor" has the meaning in A.R.S. § 36-2931.
29. "Provider" has the meaning in A.R.S. § 36-2931.
30. "Referral" is defined in 9 A.A.C. 22, Article 1.
31. "SSA" means Social Security Administration defined in P.L. 103-296, Title I.
32. "SSI" is defined in 9 A.A.C. 22, Article 1.
33. "Subcontract" is defined in 9 A.A.C. 22, Article 1.

~~**R9-28-104. Eligibility and Enrollment Related Definitions**~~
~~Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:~~

~~1. "Categorically Eligible" has the meaning in A.R.S. §§ 36-2934.~~
~~2. "Designated representative" means an individual other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another individual.~~
~~3. "Institutionalized individual" as defined for the purpose of ALTCS eligibility, means an individual who is in a medical institution or NF and receives an appropriate level of care at the NF or at an ICF/MR or who receives or will receive HCBS.~~
~~4. "Medically eligible" means meeting the ALTCS medical eligibility criteria according to Article 3.~~
~~5. "Spouse" is defined in 9 A.A.C. 22, Article 1.~~

R9-28-104. Eligibility and Enrollment Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "211" means 42 CFR 435.211.
2. "217" means 42 CFR 435.217.
3. "236" means 42 CFR 435.236.
4. "ALTCS acute care services" means services, under 9 A.A.C. 22, Article 2 and 9 A.A.C. 22, Article 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 but who lives in an acute care living arrangement described in R9-28-406(B) or who is not eligible for long-term benefits, described in R9-28-409(D), due to a transfer without receiving equal compensation.
5. "Community spouse" means the husband or wife of a person who has entered into a contract of marriage, recognized as valid by Arizona, and who does not live in a medical institution.
6. "Community Spouse Resource Deduction" means the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410(B).
7. "CSRD" means Community Spouse Resource Deduction defined in R9-28-104(6).
8. "Fair consideration" means income, real or personal property, services, or support and maintenance equal to the fair market value of the income or resources that were transferred.
9. "Institutionalized" means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution determined by the ALTCS Pre-Admission Screening (PAS) under R9-28-103.
10. "Medically eligible" means meeting the ALTCS medical eligibility criteria under 9 A.A.C. 28, Article 3.
11. "MMMNA" means Minimum Monthly Maintenance Needs Allowance.
12. "Redetermination" means a periodic review of all eligibility factors for a recipient.
13. "Representative" means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.

14. "Spouse" means either someone who is legally married under Arizona law, a person who is eligible for Social Security benefits as the spouse of another person, or a person who lives with another person of the opposite sex and the couple represents themselves in their community as husband and wife.

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

~~R9-28-401. General Provisions~~

~~A. Applications shall be processed and eligibility determined by the Administration in accordance with 42 CFR 435, Subpart J, incorporated by reference herein and on file with the Secretary of State.~~

~~B. Individuals who meet the requirements set forth in this Section, R9-28-403, and Article 3 of this Chapter shall be determined eligible to receive ALTCS services.~~

~~C. The program contractor, with whom the member is enrolled, shall notify the Administration when an ALTCS member changes residential address, county of residence or facility.~~

~~D. A designated representative is an individual other than a parent of a dependent child or a spouse, who applies for ALTCS on behalf of another individual.~~

R9-28-401. General

A. Application for ALTCS coverage.
   1. The Administration shall provide a person the opportunity to apply for ALTCS without delay.
   2. A person may be accompanied, assisted, or represented by another in the application process.
   3. To apply for ALTCS, a person shall submit a written application to an ALTCS eligibility office.
      a. The application shall contain the applicant's name and address.
      b. The application may be submitted by the applicant's representative.
      c. The application shall be signed by the person requesting ALTCS coverage or by a representative.
      d. A witness shall also sign an application if an applicant signs an application with a mark.
      e. The date of application is the date the application is received at any ALTCS eligibility office.
   4. Except when there is an emergency beyond the Administration's control, the Administration shall not delay the eligibility determination beyond the following timeframes when information necessary to make the determination has been provided or obtained:
      a. 90 days for an applicant applying on the basis of disability; or
      b. 45 days for all other applicants.
   5. The applicant or representative who files the ALTCS application may withdraw the application for ALTCS coverage either orally or in writing to the ALTCS eligibility office where the application was filed. An applicant withdrawing an ALTCS application shall receive a denial notice under subsection (H).

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), a person shall be approved for ALTCS if all conditions of eligibility for 1 of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:
   1. Categorical requirements specified in R9-28-402;
   2. Citizenship and alien status specified in R9-28-404;
   3. SSN specified in R9-28-405;
   4. Living arrangements specified in R9-28-406;
   5. Resources specified in R9-28-407;
   6. Income specified in R9-28-408;
   7. Transfers specified in R9-28-409;
   8. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any 1st-and 3rd-parties and shall cooperate by:
      a. Establishing paternity and obtaining medical support and payments, except for poverty-level women specified in R9-22-1422(C), unless the person establishes good cause for not cooperating; and
      b. Identifying and providing information to assist the Administration in pursuing 1st-and 3rd-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;
   9. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled unless the person establishes good cause for not doing so;
   10. State residency specified in R9-28-403; and
   11. Medical eligibility specified in 9 A.A.C. 28, Article 3.

C. Persons eligible for Title IV-E, Title XVI or 42 U.S.C. 1396u-1. To be determined eligible for ALTCS, a person eligible for Title IV-E (Foster Care/Adoption Subsidy), Title XVI of the Social Security Act (Supplementary Security Income), or 42 U.S.C. 1396u-1 shall provide information to determine:
   1. Medical eligibility specified in 9 A.A.C. 28, Article 3;
   2. Post-eligibility treatment of income specified in R9-28-408;
   3. Trusts in accordance with federal and state law; and
   4. Transfer of property specified in R9-28-409.

D. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria, or shall authorize the Administration to verify the following criteria:
   1. Categorical requirements specified in R9-28-402,
   2. SSN specified in R9-28-405,
   3. Living arrangements specified in R9-28-406,
   4. Resources specified in R9-28-407,
   5. Transfers of assets specified in R9-28-409,
   6. Income specified in R9-28-408,
   7. Citizenship and alien status specified in R9-28-404,
   8. 1st-and 3rd-party liability specified in subsection (B)(8),
   9. Application for potential benefits specified in subsection (B)(9),
   10. State residency specified in R9-28-403,
   11. Medical conditions specified in 9 A.A.C. 28, Article 3, and
   12. Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share-of-cost).

E. Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.

F. Eligibility effective date. Eligibility shall be effective the 1st day of the month that all eligibility requirements are met but no earlier than the prior quarter period specified in subsection (G).

G. Prior quarter.
   1. Prior quarter period. Eligibility for ALTCS medical assistance or ALTCS acute care services shall be no earlier than 3 months prior to the month of application.
   2. Prior quarter eligibility.
      a. Eligibility for prior quarter coverage is determined for each individual month in the prior quarter

period on a month-by-month basis and may be for 1, 2, or 3 months of the prior quarter period.

b. A person shall meet all eligibility criteria for ALTCS, including criteria specified in subsection (G)(2)(d) or ALTCS acute care for each approved month.

c. Eligibility may vary between ALTCS coverage and ALTCS acute care from month-to-month during the prior quarter period.

d. Only a person who resided in a NF and who is determined medically eligible under 9 A.A.C. 28, Article 3 during a prior quarter month may be eligible for ALTCS coverage for that prior quarter month.

e. A person who received home and community based services, defined in 9 A.A.C. 28, Article 2, is not eligible for ALTCS coverage during a prior quarter month, but may be eligible for ALTCS acute care services.

f. A person who does not meet the requirement in subsection (G)(2)(d) may be eligible for ALTCS acute care coverage.

H. Notice. The Administration shall send a person a written notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in 9 A.A.C. 28, Article 8 and:

1. If the applicant's eligibility is approved, the notice shall contain:
   a. The effective date of eligibility; and
   b. Post-eligibility treatment of income (share-of-cost) information (the amount the person shall pay toward the cost of care).
2. If the applicant's eligibility is denied, the notice shall contain:
   a. The effective date of the denial;
   b. A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and
   c. The legal authority supporting the decision.

I. Confidentiality. The Administration shall maintain the confidentiality of a person's record and shall not disclose the person's financial, medical, or other privacy interests except specified in R9-22-512.

~~R9-28-402. Repealed~~

R9-28-402. Categorical Requirements and Coverage Groups

A. Categorical requirements. As a condition of ALTCS eligibility, a person shall meet 1 of the following categorical requirements in this Section under 42 CFR, Part 435, Subpart F, August 18, 1994, incorporated by reference and on file with the Administration and Secretary of State. This incorporation by reference contains no future editions or amendments.

1. Aged.
   a. "Aged" means a person who is 65 years of age or older.
   b. A person is considered to be age 65 on the day before the anniversary of birth.
   c. Age shall be verified under 20 CFR 404.715 and 20 CFR 404.716, June 7, 1978, incorporated by reference and on file with the Administration and Secretary of State. This incorporation by reference contains no future editions or amendments.
2. Blind. Blindness shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2), October 31, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
3. Disabled.
   a. For a person who is age 18 or older, disability shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(3)(A) through (E), October 31, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   b. A person under age 18 is considered to be disabled for ALTCS if the person is determined medically eligible specified in 9 A.A.C. 28, Article 3.
4. Child. A child is a person defined in A.A.C. R9-22-1401(B).
5. Pregnant.
   a. Pregnancy shall be medically verified by 1 of the following licensed health care professionals:
      i. Licensed physician;
      ii. Certified physician's assistant;
      iii. Certified nurse practitioner;
      iv. Licensed midwife; or
      v. Licensed registered nurse, under the direction of a licensed physician.
   b. Written verification of pregnancy shall include the expected date of delivery.
6. A specified relative who is the caretaker relative of a deprived child specified in R9-22-1406(B) or (G) and R9-22-1418.

B. ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility the criteria in 1 of the following coverage groups:

1. A coverage group described in A.R.S. § 36-2901(4)(b).
2. The 211 coverage group specified in 42 CFR 435.211. A person in the 211 coverage group is medically eligible specified in 9 A.A.C. 28, Article 3 and who would be eligible for SSI cash assistance or the 1931 group specified in R9-22-1406 if the person is not in a medical institution.
3. The 236 coverage group specified in 42 CFR 435.236. A person in the 236 coverage group is medically eligible specified in 9 A.A.C. 28, Article 3 and the person resides in a medical institution.
4. The 217 coverage group specified in 42 CFR 435.217. A person in the 217 coverage group is medically eligible specified in 9 A.A.C. 28, Article 3 and the person resides in a home and community based setting described in R9-28-406(A)(2).

~~R9-28-403. Conditions of ALTCS Eligibility~~

~~A. U.S. citizenship or legal alienage shall be a condition of eligibility for ALTCS benefits in accordance with 42 CFR 435.402, incorporated by reference herein and on file with the Secretary of State.~~

~~B. All ALTCS members shall be residents of Arizona in accordance with 42 CFR 435.403, incorporated by reference herein and on file with the Secretary of State.~~

~~C. Institutionalized individuals who, for the purpose of being determined eligible for ALTCS, transferred assets for less than the fair market value, shall be subject to disqualification from eligibility for a certain period of time.~~

~~1. The disqualification period for transfers occurring prior to July 1, 1988, shall be calculated in accordance with Section 1917(c)(1), Section 1917(c)(2)(B)(i), (ii)(I), (iii)(I), (II), (III) and (IV) and Section 1917(c)(3) of the Social Security Act, December 22, 1987, incorporated by reference herein and on file with the Secretary of State.~~

~~2. The disqualification period for non-interspousal transfers occurring on or after July 1, 1988, and interspousal transfers occurring on or after October 1, 1989, shall be calculated in accordance with Section 1917(c)(1) of the Social Security Act, as amended by Sections 303(b) and (c) of the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, July 1, 1988, incorporated by reference herein and on file with the Secretary of State.~~

~~3. The disqualification period for interspousal transfers occurring prior to October 1, 1989, shall be calculated in accordance with paragraph (1).~~

R9-28-403. State Residency

As a condition of eligibility, a person shall be a resident of Arizona specified in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and Secretary of State. This incorporation contains no future editions or amendments.

~~**R9-28-404. Post-eligibility Treatment of Income**~~

~~A. Upon federal approval, the Administration shall calculate post-eligibility treatment of income to determine the amount, if any, that an eligible person shall contribute to the cost of his care in accordance with 42 CFR 435.725 or 42 CFR 435.726, incorporated by reference herein and on file with the Secretary of State, Section 1924(d) of the Social Security Act, December 19, 1989, incorporated by reference herein and on file with the Secretary of State, and A.R.S. § 36-2932(O).~~

~~1. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance charges that is not subject to third party reimbursement shall be deducted from the share of cost.~~

~~2. An amount for necessary medical or remedial care recognized under state law but not covered under the State Plan under Title XIX of the Social Security Act and not subject to third party reimbursement shall be deducted from the member's share of cost. Computation of the amount to be deducted shall be based on projected expenses during a prospective period not to exceed six months.~~

~~3. Members receiving home and community based services will receive a maintenance needs allowance equal to 300% of the federal benefit rate.~~

~~4. An amount shall be allotted for the maintenance of an ALTCS member's spouse who remains in the home. The amount shall be equal to the federal benefit rate or the minimum monthly maintenance needs allowance described in Section 1924(d)(3) of the Social Security Act, December 19, 1989, incorporated by reference herein and on file with the Secretary of State, minus the income of the spouse.~~

~~5. An amount shall be allotted for the maintenance of an ALTCS member's family who remains in the home. The amount shall be equal to the AFDC need standard for the number of family members or the minimum monthly maintenance needs allowance described in Section 1924(d)(3) of the Social Security Act, December 19, 1989, incorporated by reference herein and on file with the Secretary of State, minus the income of the family.~~

~~B. Contributions made on a voluntary basis from private donors, agencies, foundations, or family members shall be used to offset the cost of ALTCS services.~~

R9-28-404. Citizenship and Qualified Alien Status

As a condition of eligibility, a person shall be:

1. A citizen of the United States;
2. A qualified alien specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent consistent with federal law; or
3. A nonqualified alien who received ALTCS services on or before August 21, 1996, specified in Laws 1997, Ch. 300, § 70.

~~**R9-28-405. ALTCS enrollment and assignment**~~

~~A. The Administration shall provide verbal or written notice to the program contractor for each person to be enrolled in the program contractor's plan. Notice shall include, at a minimum, the name of the newly enrolled member, the ALTCS member identification number, and the effective date of the program contractor's liability.~~

~~B. When a member under A.R.S. Title 36, Chapter 29, Article 1, is determined eligible for ALTCS, the member's AHCCCS contractor shall be responsible for all AHCCCS covered services provided to the member until the date of the member's effective enrollment into ALTCS.~~

~~C. A person determined eligible for ALTCS who is developmentally disabled shall be enrolled with the Department of Economic Security.~~

~~D. Any person not currently eligible and enrolled under A.R.S. Title 36, Chapter 29, Article 1, who is determined eligible for ALTCS shall be directly enrolled with an ALTCS program contractor; or, in areas that do not have ALTCS program contractors, the member shall receive ALTCS covered services on a fee-for-service basis.~~

~~E. Each eligible and enrolled ALTCS member shall be assigned a case manager by the program contractor.~~

R9-28-405. Social Security Enumeration

As a condition of eligibility, a person shall furnish a SSN, specified in 42 CFR 435.910 and 435.920.

~~**R9-28-406. ALTCS discontinuance and disenrollment**~~

~~A. Members who become ineligible for ALTCS services shall receive notice of discontinuance in accordance with 42 CFR 431.210, 431.211, 431.213, and 435.919, incorporated by reference herein and on file with the Secretary of State.~~

~~B. Members who lose ALTCS eligibility due to death shall be disenrolled immediately; disenrollment shall be effective the day after the date of death.~~

~~C. Members who lose eligibility for ALTCS due to any other reason shall be disenrolled from ALTCS after appropriate discontinuance notice has been given pursuant to subsection (A) of this Section.~~

R9-28-406. ALTCS Living Arrangements

A. Long-term care living arrangements. A person may be eligible for ALTCS services, under 9 A.A.C. 28, Article 2 while living in 1 of the following settings:

1. Institutional settings:
   a. A nursing facility (NF) defined in 42 U.S.C. 1396r(a);
   b. An institution for mental disease (IMD) for a person who is either under age 21 or age 65 or older;

c. An ICF-MR for a person with developmental disabilities;
d. A hospice (free-standing, hospital, or nursing facility sub-contracted beds) defined in A.R.S. § 36-401; or

2. Home and community based services (HCBS) settings:
a. A person's home defined in R9-28-101(B); or
b. Alternative HCBS settings defined in R9-28-101(B).

B. ALTCS acute care living arrangements. A person applying for or receiving ALTCS coverage shall be eligible for only ALTCS acute care coverage in the following living arrangements, settings, or locations:
1. The income limit is 300% of the FBR for a person meeting the requirements of the 236 coverage group specified in R9-28-402(B) and who resides in 1 of the following settings:
a. A noncertified medical facility; or
b. A medical facility registered with AHCCCS but does not have a contract with an ALTCS program contractor; or
c. A location outside of Arizona if the person is temporarily absent from Arizona.
2. The income limit is 100% of the FBR for a person who does not meet the requirements of the 217 or 236 coverage groups specified in R9-28-402(B) and who resides in 1 of the following settings:
a. At home or in an alternative HCBS setting if a person refuses HCBS service;
b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with AHCCCS;
c. At home or in an alternative HCBS setting if the person requests but does not receive HCBS due to the federal limit on HCBS that can be provided by the state.
d. A room-and-board home;
e. An unlicensed care home;
f. An EPD disabled residence in a Level III Behavioral Health Facility; or
g. A commercially-operated facility that provides some HCBS.

C. Inmate of a public institution. An inmate of a public institution is not eligible for the ALTCS program if federal financial participation (FFP) is not available.

~~R9-28-407. ALTCS retroactive coverage~~
~~A. ALTCS eligible individuals shall, when the conditions of subsection (B) of this Section are met, receive retroactive coverage for ALTCS covered services in the three month period prior to the first day of the month of application.~~
~~B. An individual shall be determined eligible for ALTCS retroactive coverage if the following conditions are met:~~
~~1. The individual is not currently categorically eligible for AHCCCS;~~
~~2. The individual needed and received ALTCS covered services during the preceding three month period; and~~
~~3. The individual would have been financially and medically eligible for ALTCS had the individual applied at the time the services were rendered.~~
~~C. Retroactive coverage shall not be provided for any period prior to December 19, 1988 for the developmentally disabled and January 1, 1989 for the aged and physically disabled.~~

R9-28-407. Resource Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI),
2. A person receiving Title IV-E Foster Care Maintenance payment,
3. A person receiving a Title IV-E Adoption Assistance, or
4. A person described in Section 1931 of the Social Security Act 42 U.S.C. 1396u-1, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. Except as provided in subsection (D)(1), if a person's Medicaid eligibility is most closely related to SSI, and is not included in subsection(A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(2)(B) and (b), August 15, 1994, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. Except as provided in subsections (D)(1) and (D)(2), if a person's Medicaid eligibility is most closely related to 42 U.S.C. 1396u-1, and is not included in subsection(A), the Administration shall use the resource criteria to determine eligibility specified in A.A.C. R9-22-1426 through A.A.C. R9-22-1427.

D. The Administration permits exceptions to the resource criteria for a person identified in subsections (B) and (C):
1. Resources of a responsible relative (spouse or parent) are disregarded beginning the 1st day in the month the person is institutionalized.
2. The value of household goods and personal effects is excluded.
3. The value of oil, timber, and mineral rights is excluded.
4. The value of all of the following shall be disregarded:
a. Term insurance;
b. Burial insurance;
c. Assets that a person has irrevocably assigned to fund the expense of a burial;
d. The cash value of all life insurance if the face value does not exceed $1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or declaratively designated as a burial fund;
e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
f. At the time of eligibility determination, $1,500 of the equity value of an asset declaratively designated as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement; and
g. If the person remains continuously eligible, all appreciation in the value of the assets in subsections (D)(1)(d) through (D)(1)(d) will be disregarded;
5. For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(h)(1), September 30, 1989, and 42 U.S.C. 1396r-5(c), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

6. Trusts are evaluated in accordance with federal and state laws to determine eligibility.

E. A person is not eligible for long-term care services if countable resources exceed the following limitations:
1. For a SSI-related person identified in subsection (B), the limit is $2,000 or $3,000 per couple under 20 CFR 416.1205, September 26, 1985, incorporated by reference and on file with the Administration and the Office of Secretary of State. The incorporation by reference contains no future editions or amendments;
2. For a person in subsection (C), the limit is $2,000 as specified in R9-22-1427; and
3. For a person eligible for S.O.B.R.A., there is no resource limit specified in R9-22-1406(I) and (J).

F. A person shall provide information and verification necessary to determine the countable value of resources.

R9-28-408. Income Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the income requirements for eligibility unless ineligible due to a trust in accordance with federal and state law.
1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance Payments;
3. A person receiving Title IV-E Adoption Assistance; or
4. A person described in Section 1931 of the Social Security Act 42 U.S.C. 1396u-1, July 1, 1997, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. Except as provided in subsection (D), if a person's Medicaid eligibility is most closely related to SSI and the person is not included in subsection(A), the Administration shall use the methodology in 42 U.S.C. 1382(a), August 15, 1994, incorporated by reference and on file with the Administration and the Secretary of State, to determine eligibility. This incorporation by reference contains no future editions or amendments.

C. Except as provided in subsection (D), if a person's Medicaid eligibility is most closely related to 42 U.S.C. 1396u-1 and the person is not included in subsection(A), the methodology in R9-22-1428 through R9-22-1430 and 42 U.S.C. 1396a(a)(17)(D) is used to determine eligibility. 42 U.S.C. 1396u-1, July 1, 1997 and 42 U.S.C. 1396a(a)(17)(D), November 5, 1990, are incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments.

D. The following are income exceptions.
1. The following are income exceptions for a person identified in subsections (B) and (C):
   a. Disbursements from a trust are considered in accordance with federal and state law;
   b. Income types excluded by 42 U.S.C. 1382a(b), August 22, 1996, incorporated by reference and on file with the Administration and the Secretary of State and not including any future editions or amendments, for determining net income are also excluded in determining gross income to determine eligibility;
   c. Income of a responsible relative (parent or spouse) is counted as part of income in accordance with 42 CFR 435.602, except that the income of a responsible relative is disregarded the month the person is institutionalized. 42 CFR 435.602, August 22, 1994, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments; and
   d. For a person defined in 42 U.S.C. 1396r-5(h)(1) income is calculated for the institutionalized spouse in accordance with 42 U.S.C. 1396r-5(b), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. For a person identified in subsection (B), in-kind support and maintenance specified in 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests.
3. The following are income exceptions to SSI methodology for the net income test:
   a. For a person living with a spouse, the computation rules for an eligible couple are followed for the net income calculation, even if the spouse is not receiving or applying for SSI or Medicaid benefits;
   b. For a couple living with a child defined in R9-22-1507(A)(2), a child allocation using the methodology described in 20 CFR 416.1163(b)(1) and (2) is allowed as a deduction from the combined net income of the couple for each child regardless of whether a child is eligible for SSI or Medicaid benefits. Each child's allocation is reduced by that child's income, including public income maintenance payments. 20 CFR 416.1163(b)(1) and (2), May 4, 1989, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments;
   c. For a person who is not living with a spouse but is living with a child defined in R9-22-1507(A)(2), a deduction from the parent's net income using the methodology described in 20 CFR 416.1163(b)(1) and (2) is allowed as an allocation for each child regardless of whether the child is ineligible or eligible. Each child's allocation is reduced by that child's income, including public income maintenance payments. 20 CFR 416.1163(b)(1) and (2), May 4, 1989, are incorporated by reference and on file with the Administration and the Secretary of State and contain no future editions or amendments; and
   d. For a child defined in R9-22-1507(A)(2), income is deemed available from an SSI cash or Medicaid-ineligible parent by allowing an allocation for each SSI cash program or Medicaid-eligible and ineligible child of the parent as a deduction from the parent's income using the methodology described in 20 CFR 416.1165(b). Each child's allocation shall be reduced by that child's income, including public income maintenance payments. 20 CFR 416.1165(b), January 8, 1997, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments.

E. As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:
1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300% of the FBR;
2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100% of the FBR;

3. For a person who is S.O.B.R.A-related specified in A.A.C. R9-22-1406(I) and R9-22-1406(J) and is:
   a. A child born after September 30, 1983, who is at least age 6 but less than age 19; 100% of the FPL, adjusted by household size;
   b. A child age 1 through 5, 133% of the FPL, adjusted by household size; or
   c. A child less than age 1 or a pregnant woman, 140% of the FPL, adjusted by household size; or
4. For a person whose eligibility is determined under Section 1931 of the Social Security Act under 42 U.S.C. 1396u-1, including a child less than the age of 18 who meets the eligibility criteria for Ribicoff or a caretaker relative of a deprived child, the standards specified in R9-22-1406(H) shall apply. Section 1931 of the Social Security Act under 42 U.S.C. 1396u-1, July 1, 1997, is incorporated by reference and on file with the Administration and the Secretary of State and contains no future editions or amendments.

F. The Director shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. 42 CFR 435.725, January 19, 1993, and 42 CFR 435.726, July 25, 1994, are incorporated by reference and on file with the Administration and the Secretary of State. These incorporations by reference contain no future editions or amendments. The Director shall consider the following in determining the share-of-cost:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost;
2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost;
3. The share-of-cost of a person with a spouse is calculated as follows:
   a. If an institutionalized person has a community spouse defined in 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments;
   b. If an institutionalized person has a spouse who does not live at home but is absent due to marital estrangement, or who resides in a medical institution, or in an approved setting specified in R9-28-504, only the institutionalized person's income is used for the share-of-cost. The spousal deduction described in subsection (F)(5)(b) is not allowed; and
   c. For all other persons, the share-of-cost is calculated by dividing the combined income of the spouses in half;
4. Income assigned to a trust is considered in accordance with federal and state law.
5. The following expenses are deducted from the share-of-cost of an eligible person to calculate their share-of-cost:
   a. A personal-needs allowance equal to 15% of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300% of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
   b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
   c. A family allowance equal to the standard for the 1931 coverage group specified in R9-22-1406(B) for the number of family members minus the income of the family members if a spouse and children remain at home;
   d. Expenses for the medical and remedial care services listed in subsection (F)(6) if these expenses have not been paid or are not subject to payment by a 3rd-party, but the person still has the obligation to pay the expense, and 1 of the following conditions is met:
      i. The expense represents a current payment (that is, a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred) and the expense has not previously been allowed a share-of-cost deduction; or
      ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously deducted from the share-of-cost;
   e. An amount determined by the Director for the maintenance of a single person's home for not longer than 6 months if a physician certifies that the person is likely to return home within that period; or
   f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to 3rd-party reimbursement; and
6. In the post-eligibility calculation of income, the Administration recognizes the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor to a person determined to need institutional services under this Article when the medical or remedial care services are medically necessary for a person:
   a. Nonemergency dental services for a person who is age 21 or older;
   b. Hearing aids and hearing aid batteries for a person who is age 21 or older;
   c. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
   d. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
   e. Orthognathic surgery for a person 21 years of age or older; and
   f. On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.

G. A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203, November 26, 1985, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.

R9-28-409. Transfer of Assets

A. The provisions in this Section apply to an institutionalized person who has, or whose spouse has, transferred assets and received less than the fair market value (uncompensated

value) specified in A.R.S. § 36-2934(B) and 42 U.S.C. 1396p(c)(1)(A), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. A person shall report transfer of assets. The Administration shall evaluate all transfers occurring during or after the look-back period under 42 U.S.C. 1396p(c)(1)(B), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The person shall provide verification of any transfer.

C. Certain transfers are permitted under 42 U.S.C. 1396p(c)(2), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

D. If the Administration determines a disqualification period applies due to a transfer, and the person is otherwise eligible, the person may remain eligible for ALTCS acute care services but shall be disqualified for receiving ALTCS coverage under 42 U.S.C. 1396p(c)(1)(C), August 10, 1993, which is incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.

E. The period of disqualification for transfers shall be computed by dividing the cumulative uncompensated value of the transferred assets by the average cost for a private pay patient for nursing care services at the time of application.

1. For single or multiple transfers occurring in the same calendar month, the sum of all uncompensated value shall be divided by the monthly private pay rate. Disregarding fractions, the result of this calculation equals the number of months of ineligibility.
2. For multiple transfers occurring in different calendar months, the total uncompensated value for each transfer of assets shall be determined under subsection (E)(1), but if the periods of ineligibility overlap, the period of ineligibility shall run consecutively. Fractions are disregarded at the end of the entire period.
3. For multiple transfers occurring in different months, the total uncompensated value for each transfer shall be determined under subsection (E)(1), but if the periods of ineligibility do not overlap, each period of ineligibility shall be treated under subsection (E)(1).

F. Transfers of assets for less than fair market value are presumed to have been made to establish eligibility for ALTCS services.

G. Rebuttal of disqualification.

1. A person found ineligible for ALTCS services by reason of a transfer of assets for uncompensated value shall have the right to rebut the disqualification under 42 U.S.C. 1936p(c)(2)(C), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. The person shall have the burden of rebutting the presumption.
3. If a person rebuts a transfer on the basis of debt repayment, the Administration shall determine the validity of the debt under A.R.S. § 44-101.

H. Undue hardship. A period of disqualification for ALTCS services due to a transfer may be waived by the Director if the person is otherwise eligible and a substantial showing is made by clear and convincing evidence that:

1. The person is unable to obtain necessary medical care without ALTCS eligibility, and
2. Is in imminent danger of death.

R9-28-410. Community Spouse

A. The methodology in this Section applies to an institutionalized person who is legally married and has a spouse who resides in the community.

B. If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407:
   a. Resources owned by a couple at the beginning of the 1st continuous period of institutionalization from and after September 30, 1989, shall be computed from the 1st day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to 1/2 of the total value, are computed under 42 U.S.C. 1396r-5(c)(1), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.
   b. The Community Spouse Resource Reduction (CSRD) is calculated under 42 U.S.C. 1396r-5(f)(2), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   c. The CSRD is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
      i. Resources in excess of the CSRD must be equal to or less than the standard for a person specified in R9-28-407.
      ii. The CSRD is allowed as a deduction for 12 consecutive months beginning with the 1st month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.
      iii. If a person, previously eligible for ALTCS using the community spouse policy, reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSRD will be allowed as a deduction from resources for another 12-month period.
2. Resources are excluded specified in R9-28-407, except that 1 vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.

3. The Director may grant eligibility if the Administration determines a denial of eligibility would create an undue hardship.

C. The community spouse policy applies to the income eligibility and post-eligibility treatment of income beginning September 30, 1989, regardless of when the 1st period of institutionalization began.
1. Income payments are attributed to the institutionalized spouse and the community spouse under 42 U.S.C. 1396r-5(b)(2), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. Income is excluded specified in R9-28-408.
3. The institutionalized spouse's income eligibility is determined under community property rules in which the income of the spouse is combined and divided by 2. Income eligibility shall be based on the income received in the person's name if the person is not eligible using community property rules.
4. The items described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized spouse's income in determining share-of-cost and 42 U.S.C. 1396r-5(d)(1) and (2), September 30, 1989, are incorporated by reference and on file with the Administration and the Secretary of State and contain no future editions or amendments:
   a. A personal-needs allowance specified in R9-28-408(f)(5)(a);
   b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;
   c. A family allowance for each family member equal to 1/3 of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance;
   d. An amount for medical or remedial services specified in R9-28-408; and,
   e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to 3rd-party reimbursement.

D. Transfers.
1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRD without affecting eligibility under 42 U.S.C. 1396r-5(f), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The institutionalized spouse may transfer resources to:
   a. The community spouse; or
   b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.
2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the 1st month of eligibility, to transfer resources in excess of the resource standard in R9-28-407(E)(2) to the persons listed in subsection (D)(1).
3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.

E. Specific hearing rights apply to a person whose eligibility is determined under this Section.
1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:
   a. The community spouse monthly income allowance;
   b. The amount of monthly income allocated to the community spouse;
   c. The computation of the spousal share of resources;
   d. The attribution of resources; or
   e. The CSRD.
2. The hearing officer may increase the amount of the MMMNA if either spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
3. The hearing officer may increase the amount of the CSRD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The community spouse may be allowed to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

R9-28-411. Changes, Redeterminations, and Notices

A. Reporting and verifying changes.
1. A person shall report to the ALTCS eligibility office the following changes for a person, a person's spouse, or a person's dependent children under 42 CFR 435.916:
   a. A change of address;
   b. An admission to or discharge from a medical facility, public institution, or private institution;
   c. A change in the household's composition;
   d. A change in income;
   e. A change in resources;
   f. A determination of eligibility for other benefits;
   g. A death;
   h. A change in marital status;
   i. An improvement in the person's medical condition;
   j. A change in school attendance;
   k. A change in Arizona state residency;
   l. A change in citizenship or alien status;
   m. Receipt of a SSN under R9-28-405;
   n. A transfer of assets under R9-28-409;
   o. A change in trust income and disbursements in accordance with state and federal law;
   p. A change in 1st-or 3rd-party liability that may be responsible for payment of all or a portion of the person's medical costs;
   q. A change in 1st-party medical insurance premiums;
   r. A change in the household expenses used to calculate the community spouse monthly income allowance described in R9-28-410;
   s. A change in the amount of the community spouse monthly income allowance that is provided to the community spouse by the institutionalized spouse under R9-28-410; and
   t. Any other change that may affect the person's eligibility or share-of-cost.
2. A change shall be reported either orally or in writing and shall include:
   a. The name of the affected person;
   b. The change;
   c. The date the change happened;
   d. The name of the person reporting the change; and
   e. The person's Social Security or case number, if known, under A.R.S. § 36-2934.

3. A person shall provide verification of changes upon request, under A.R.S. § 36-2934, if needed to redetermine eligibility or to re-calculate post-eligibility computation of income.
4. A person shall report anticipated changes in advance, as soon as the future event becomes known.
5. A person shall report other changes events within 10 days of the date the change occurred.

B. Processing of changes and redeterminations. A person's eligibility shall be redetermined at least 1 time every 12 months and when changes occur, under 42 CFR 435.916. A person's share-of-cost, specified in R9-28-408, shall be redetermined whenever a change occurs that may affect the post-eligibility computation of income.

C. Actions that may result from a redetermination or change. Processing a redetermination or change shall result in 1 of the following findings:
1. No change in eligibility or the post-eligibility computation of income;
2. Discontinuance of eligibility if a condition of eligibility is no longer met;
3. Suspension of eligibility if a condition of eligibility is temporarily not met;
4. A change in the post-eligibility computation of income and the person's share-of-cost; or
5. A change in service from ALTCS to ALTCS acute care services, or from ALTCS acute care services to ALTCS, caused by changes in a person's living arrangement, specified in R9-28-406, or a transfer of assets specified in R9-28-409.

D. Notices.
1. Contents of notice. The Administration shall issue a notice when an action is taken regarding a person's eligibility or computation of share-of-cost. The notice shall contain the following information:
   a. A statement of the action being taken;
   b. The effective date of the action;
   c. The specific reason for the intended action;
   d. The actual figures used in the eligibility determination and specify the amount by which the person exceeds income standards if eligibility is being discontinued because either a person's resources exceed the resource limit specified in R9-28-407(E), or a person's income exceeds the income limit specified in R9-28-408(E);
   e. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
   f. An explanation of a person's right to request an evidentiary hearing; and
   g. An explanation of the date by which a request for hearing must be received so that eligibility or the current share-of-cost may be continued.
2. Advance notice of changes in eligibility or share-of-cost. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of change, under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever the following adverse action is taken:
   a. To discontinue or suspend eligibility if an eligible person no longer meets a condition of eligibility, either ongoing or temporarily;
   b. To affect post-eligibility computation of income and increase a person's share-of-cost; or
   c. To reduce benefits from ALTCS to ALTCS acute care services due to a change from a long-term care living arrangement to an acute care living arrangement, specified in R9-28-406(B), or due to a transfer with uncompensated value, specified in R9-28-409.
3. Under 42 CFR 431.213, notice shall be issued to a person to discontinue eligibility or to increase the share-of-cost, no later than the effective date of action if:
   a. A person provides a clear, written statement, signed by the person, that a person no longer desires services;
   b. A person provides information that requires termination of eligibility or an increase in the share-of-cost and the person signs a clear written statement waiving advance notice;
   c. A person cannot be located and mail sent to that person has been returned as undeliverable;
   d. A person has been admitted to a public institution where the person is ineligible for ALTCS under R9-28-406; or
   e. A person has been approved for Medicaid in another state;
   f. The Administration has information that confirms the death of the person;
   g. The person's primary care provider has prescribed a change in the level of medical care; or
   h. The notice involves an adverse determination regarding the PAS, specified in A.R.S. § 36-2536.

E. Transitional. HCBS services may be provided to a person who is no longer at risk of institutionalization but who continues to require significant long-term care services under A.R.S. § 36-2936(D).

R9-28-412. Enrollment with an ALTCS Program Contractor

A. Enrollment with appropriate ALTCS program contractor. As soon as a decision is reached that a person is eligible for ALTCS benefits, a person shall be enrolled under A.R.S. § 36-2933 with either:
1. The DES Division of Developmental Disabilities if a person is developmentally disabled;
2. An ALTCS tribal contractor if the person is a Native American living on the reservation of a tribe participating as an ALTCS tribal contractor;
3. An ALTCS program contractor; or
4. ALTCS fee-for-service if there is no ALTCS tribal or program contractor and the person is not developmentally disabled.

B. Effective date of ALTCS enrollment for a person not enrolled with an acute care health plan.
1. With the exception of prior quarter eligibility under R9-28-401(G), a person shall be enrolled with the appropriate program contractor, as determined by subsection (A), retroactive to the 1st day of the month in which the person became eligible for the ALTCS program.
2. Prior quarter eligibility benefits, specified in R9-28-401(G), are covered by the Administration on a fee-for-service basis.

C. Effective date of ALTCS enrollment for a person enrolled with an acute care health plan. If a person is eligible for AHCCCS acute care program and is approved for ALTCS coverage, disenrollment with a contractor who provides services specified in R9-22-101 and enrollment with the ALTCS tribal or program contractor is effective on the date

that the ALTCS approval is posted on the AHCCCS Prepaid Medical Management Information System (PMMIS). The contractor in which the person is enrolled is responsible for AHCCCS covered services until that date.

D. Notification to the ALTCS tribal or program contractor. A contractor shall be notified whenever a person is enrolled or disenrolled with that contractor. Notification shall include the person's name, identification number, and the effective date of enrollment or disenrollment.

E. Responsibilities of ALTCS tribal or program contractors.

1. The ALTCS program contractor is responsible for all AHCCCS covered services provided to an enrolled person until the person is disenrolled.
2. An eligible and enrolled person shall be assigned a case manager by the ALTCS program contractor.
3. The ALTCS tribal contractor is responsible for the coordination of services specified in the tribe's intergovernmental agreement (IGA) with the Administration.
4. The ALTCS tribal or program contractor shall notify the Administration if an ALTCS eligible person has any change that may affect eligibility including:
   a. Residential address;
   b. County of residence;
   c. Facility; or
   d. Death.

F. Disenrollment.

1. An eligible person who dies shall be disenrolled from the ALTCS tribal or program contractor effective the day after the date of death.
2. An eligible person who loses ALTCS eligibility for any other reason shall be disenrolled following the receipt of appropriate notification under R9-28-411.

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 9. DEPARTMENT OF ADMINISTRATION
SCHOOL BUSES

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**
   R17-9-109 — New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
   Authorizing statute: A.R.S. § 28-3228(C)
   Implementing statute: A.R.S. §§ 28-3228 and 41-1072 et seq.

3. **The effective date for the rule:**
   January 5, 1999

4. **List of all previous notices appearing in the register addressing the proposed rule:**
   Notice of Docket Opening, 4 A.A.R. 2845, (October 2, 1998).
   Notice of Proposed Rulemaking, 4 A.A.R. 3004, (October 16, 1998).

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
   Name: Jeanne Hann
   Address: 1400 West Washington Street, Suite 270
   Phoenix, Arizona 85007
   Telephone: (602) 542-2006
   Fax: (602) 542-1486

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**
   The agency is complying with A.R.S. §§ 41-1072 et seq, which require all agencies that issue licenses to establish time-frames within which they will either grant or deny each type of license issued.

7. **A reference to any study that the agency proposes to rely on in its evaluation of or justification for the proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:**
   None.

8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

9. **The summary of the economic, small business, and consumer impact:**
   The rule imposes an administrative burden on the agency. Because the agency already issues the certifications involved, the time-frames will have a minimal economic impact on the agency. The rule imposes no burden on small businesses or consumers. The rule provides certainty regarding the amount of time required for certification to those who seek certification and those

who employ them. The economic impact on other state agencies, such as the Office of the Secretary of State and the Governor's Regulatory Review Council, is expected to be minimal.

10. **A description of the changes between the proposed rules, including supplemental notices, and final rules:**
Minor changes were made in response to comments from Council staff. The appeal rights of an applicant who fails to submit required information were preserved by adding a subsection providing the applicant with the option to have the certification application denied rather than closed.

11. **A summary of the principal comments and the agency response to them:**
No comments about the proposed rulemaking were received.

12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
None.

13. **Incorporations by reference and their location in the rules:**
None.

14. **Whether the rule was previously made as an emergency rule and, if so, whether the text was changed between making as an emergency and the making of these final rules:**
The rule was not previously made as an emergency rule.

15. **The full text of the rule follows:**

TITLE 17. TRANSPORTATION

CHAPTER 9. DEPARTMENT OF ADMINISTRATION SCHOOL BUSES

ARTICLE 1. SCHOOL BUS MINIMUM STANDARDS

Section
R17-9-109. Time-frames for Making Certification Determinations

ARTICLE 1. SCHOOL BUS MINIMUM STANDARDS

R17-9-109. Time-frames for Making Certification Determinations

A. For certification as a school bus driver, classroom instructor, or behind-the wheel instructor, the time-frames required by A.R.S. § 41-1072 et. seq. are:
1. Overall time-frame: 60 days
2. Administrative completeness review time-frame: 45 days
3. Substantive review time-frame: 15 days

B. An administratively complete application for certification consists of all the information and documents listed in:
1. R17-9-102(A) for a school bus driver,
2. R17-9-103(A) for a classroom instructor, and
3. R17-9-103(D) for a behind-the-wheel instructor.

C. An administrative completeness review time-frame, as described in A.R.S. § 41-1072(1) and listed in subsection (A)(2), begins on the date the Department receives an application.
1. If the application is not administratively complete when received, the Department shall send a notice of deficiency to the applicant. The deficiency notice shall state the documents and information needed to complete the application.
2. Within 120 days from the postmark date of the deficiency notice, the applicant shall submit to the Department the missing documents and information. The time-frame for the Department to finish the administrative completeness review is suspended from the postmark date of the deficiency notice until the date the Department receives the missing documents and information.
3. If the applicant fails to provide the missing documents and information within the time provided, the Department shall close the applicant's file. An applicant whose file is closed and who wants to be certified shall apply again under R17-9-102 or R17-9-103.
4. If the application is administratively complete, the Department shall send a written notice of administrative completeness to the applicant.

D. A substantive review time-frame, as described in A.R.S. § 41-1072(3) and listed in subsection (A)(3), begins on the postmark date of the notice of administrative completeness.
1. During the substantive review time-frame, the Department may make 1 comprehensive written request for additional information.
2. The applicant shall submit to the Department the additional information identified in the request for additional information within 20 days from the postmark date of the request for additional information. The time-frame for the Department to finish the substantive review of the application is suspended from the postmark date of the request for additional information until the Department receives the additional information.
3. Unless an applicant requests that the Department deny certification within the 20-day period in subsection (D)(2), the Department shall close the file of an applicant who fails to submit the additional information within the 20 days provided. An applicant whose file is closed and who wants to be certified shall apply again under R17-9-102 or R17-9-103.
4. When the substantive review is complete, the Department shall inform the applicant in writing of its decision whether to certify the applicant.
   a. The Department shall deny certification if it determines that the applicant does not meet all substantive criteria for certification required by statute and rule. An applicant who is denied certification may appeal the Department's decision under A.R.S. § 41-1092 et seq. and any rules adopted under A.R.S. § 41-1092.01(C)(4).

b. The Department shall grant certification if it determines that the applicant meets all substantive criteria for certification required by statute and rule.

NOTICE OF FINAL RULEMAKING

TITLE 19. ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING

CHAPTER 1. DEPARTMENT OF LIQUOR LICENSES AND CONTROL

PREAMBLE

1. **Sections Affected** / **Rulemaking Action**

Article 3	Amend
R19-1-303	New Section
Table A	New Table

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
   Authorizing Statute: A.R.S. 4-112(B)

   Implementing Statutes: A.R.S. Title 41, Chapter 6, Article 7.1

3. **The effective date of the rules:**
   January 8, 1999

4. **A list of all previous notices appearing in the Register addressing the final rule:**
   Notice of Docket Opening: 4 A.A.R. 959, April 24, 1998.
   Notice of Proposed Rulemaking: 4 A.A.R. 2164, August 7, 1998.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Myron F. Musfeldt
Address:	800 W. Washington, 5th Floor Phoenix, Arizona 850007
Telephone:	(602) 542-9041
Fax:	(602) 542-6799

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**
   A.R.S. 41-1073 requires adoption of the time-frames during which the agency will grant or deny each type of license that it issues.

7. **A reference to any study that the agency proposes to rely on in it's evaluation of or justification for the final rule and where the public may obtain or review the study, all data underlying each study, any analysis if the study and other supporting material:**
   None

8. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable

9. **The summary of the economic, small business and consumer impact:**
   No impact on consumers or small business.

10. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
    Eliminated retroactive effective date in the proposed rules.

11. **A summary of the principal comments and the agency response to them:**
    No comments

12. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
    Under A.R.S. § 4-201.01(B), the Director has the authority to extend time-frames for cause.

13. **Incorporations by reference and their locations in the rules:**
    None

14. Was this rule previously adopted as an emergency rule?
No

15. The full text of the rules follows:

TITLE 19. ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING

CHAPTER 1. DEPARTMENT OF LIQUOR LICENSES AND CONTROL

ARTICLE 3. UNLICENSED PREMISES DEFINITIONS AND LICENSING TIME-FRAMES ~~HEARING PROCEDURES~~

Section

R19-1-303. Licensing Time-frames

Table A Licensing Time-frames Table

ARTICLE 3. UNLICENSED PREMISES DEFINITIONS AND LICENSING TIME-FRAMES ~~HEARING PROCEDURES~~

R19-1-303. Licensing Time-frames

The following time-frames apply to licenses issued by the Department. The licensing time-frames consist of an administrative completeness review time-frame, a substantive review time-frame, and an overall time-frame as defined in A.R.S. § 41-1072.

1. Within the applicable administrative completeness review time-frame set forth in subsection (5), the Department shall notify the applicant in writing when an application is incomplete. The notice shall specify what information or component is required to make an application complete.
2. An applicant with an incomplete application shall supply the missing information within 30 days from the date of the notice or within such further time as the Director may specify, unless another time is specified by statute or rule. If the applicant fails to submit the missing information or component within the specified time period, the Department may deem the application withdrawn and close the file. Closing the file under this provision does not preclude the applicant from filing a new application.
3. Within the applicable overall time-frame set forth in subsection (5), unless extended by written notification pursuant to A.R.S. § 4-201.01(B), or by mutual agreement pursuant to A.R.S. § 41-1075, the Department shall notify the applicant in writing that the application is granted or denied. If the application is denied, the Department shall serve the applicant with a written order containing justification for the denial and an explanation of the applicant's right to appeal.
4. For all types of liquor licenses, except Special Event and Wine Festival Licenses, the Director may extend the overall time-frame as prescribed by A.R.S. § 4-201(B).
5. The licensing time-frames are set forth in Table A.

TABLE A:
Licensing Time-frames Table

No.	License Type	Legal Authority	Administrative Completeness Review Time-frame	Substantive Review Time-frame	Overall Time-frame
1	In-State Producers	A.R.S. § 4-209	75 Days	30 Days	105 Days
2	Out of State Producers	A.R.S. § 4-209	75 Days	30 Days	105 Days
3	Domestic Microbrewery	A.R.S. § 4-205.04	75 Days	30 Days	105 Days
4	Wholesalers	A.R.S. § 4-209	75 Days	30 Days	105 Days
5	Government	A.R.S. § 4-205.03	75 Days	30 Days	105 Days
6	Bar	A.R.S. § 4-209	75 Days	30 Days	105 Days
7	Beer and Wine Bar	A.R.S. § 4-209	75 Days	30 Days	105 Days
8	Conveyance	A.R.S. § 4-209	75 Days	30 Days	105 Days
9	Liquor Store	A.R.S. § 4-209	75 Days	30 Days	105 Days
10	Beer and Wine Store	A.R.S. § 4-209	75 Days	30 Days	105 Days
11	Hotel-Motel	A.R.S. § 4-205.01	75 Days	30 Days	105 Days
12	Restaurant	A.R.S. § 4-205.02	75 Days	30 Days	105 Days
13	Domestic Farm Winery	A.R.S. § 4-205.04	75 Days	30 Days	105 Days
14	Club (Private)	A.R.S. § 4-205	75 Days	30 Days	105 Days
15	Out of State Winery	A.R.S. § 4-209	75 Days	30 Days	105 Days
	Wine Festival/Wine Fair	A.R.S. § 4-203.03	10 Days	20 Days	30 Days
	Special Event	A.R.S. § 4-203.02(B)	10 Days	20 Days	30 Days